Maureen Malcolm, M.A., LPC

CONSENT FOR RELEASING AND RETRIEVING INFORMATION

NOTE: *If consultation is requested and information is to be exchanged between this provider and a third party, the name, address, and phone number of the designated third party should be listed in both the release and retrieve sections below.*

Client Name: _____Date: _____

I hereby consent *Karen L. Caswell* to **RELEASE** information to the below listed parties. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination of care.

Parties to **RELEASE** information to:

Name	Address	Phone Number

I hereby consent *Karen L. Caswell* to **RETRIEVE** information from the below listed parties. This includes written and verbal transfer of information, as well as mental health and treatment information for the purposes of consultation and coordination of care.

Parties to **RETRIEVE** information from:

Name	Address	Phone Number

I certify that this authorization to release and retrieve information has been made voluntarily. I understand the information to be released and retrieved may include information related to drug and/or alcohol abuse. The information may also include HIV/AIDS conditions.

I understand that I may revoke this authorization at any time by written notice to Karen L. Caswell, except to the extent that Karen L. Caswell has already taken action on the request. This authorization will expire 6 months from the date treatment is terminated.

_____ _____

Signature of Client or Guardian Date

_____ _____

Witness Date