

# Wellspring Christian Counseling

## CONSENT FOR THE RELEASE OF INFORMATION OR RECORDS

This will authorize:

\_\_\_\_\_  
(Name and Title of Wellspring Christian Counseling Staff Member)

to ( ) obtain from: \_\_\_\_\_ and/or ( ) release to:

\_\_\_\_\_  
(Facility/Agency/Person)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code) (Telephone)

verbal, written, and/or duplicate information concerning:

\_\_\_\_\_  
(Client Name) (Date of Birth)

\_\_\_\_\_  
(Client Name) (Date of Birth)

Specific type of information to be released:

\_\_\_\_\_  
\_\_\_\_\_

Purpose for this release:

\_\_\_\_\_  
\_\_\_\_\_

In signing this Consent, I do so with the understanding that this form amounts to a waiver of any claim I might assert against Wellspring Christian Counseling for the release of this information. I understand that I may revoke this Consent at any time by informing any of the above noted individuals and/or organizations.

This information shall be kept confidential and will not be released to any other agencies, persons, or facilities according to the Redislosure Act. (REDISCLASURE ACT: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations 42 C.F.R., Part 2, prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information in not sufficient for this purpose.)

\_\_\_\_\_  
(Client Signature) (Date)

\_\_\_\_\_  
(Client Signature) (Date)

\_\_\_\_\_  
Parent or Guardian Signature) (Date)