Consent To Release or Obtain Information

Name of Client/Evaluee: __________________________________________ Date of Birth: _____________________

INFORMATION TO BE □ RELEASED TO □ OBTAIN FROM □ DISCUSSED WITH:

Name: _______________________________________________________ Telephone #: _____________________
Address: _____________________________________________________ Fax #: ______________________
City: _________________________________________________________ State: _______ Zip: ___________

TYPES OF INFORMATION TO BE RELEASED: I permit (insert agency or CRC name), to release, obtain, and/or discuss the following information to the person or entity identified above. I understand that (insert agency or CRC name), may need my written consent to release, obtain, and/or discuss information about testing, diagnosis, and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases including HIV/AIDS, genetic information or psychiatric/psychological/mental health information. Based on the boxes I have checked below, (insert agency or CRC name) may release, obtain, and/or discuss all diagnostic, procedural, claim, or other related information and records.

☐ General Health Care (Claims, Billing, Eligibility information not related to the sensitive categories listed below)
☐ Alcohol and Chemical Dependency
☐ Reproductive Health
☐ Sexually Transmitted Diseases
☐ Genetic Information
☐ Psychiatric/psychological/behavioral health/mental health
☐ Psychotherapy notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

TIME FRAME OF RELEASE: Unless I revoke this consent, it will remain in effect for 12 months from the date of my signature. I may change my mind and revoke this consent at any time. To do so, I will inform (insert agency or CRC name) in writing.

This consent form may be transmitted by facsimile, electronic mail, or regular mail.

Printed Name of Client/Evaluee ___________________________ Date ______________

Signature of Client/Evaluee

Printed Name of Legal Guardian (if applicable) ___________________________ Date ______________

Signature of Legal Guardian (if applicable)


This consent form is provided by the Commission on Rehabilitation Counselor Certification (CRCC) as a sample of the content that may be appropriate to include. CRCC does not endorse this as being appropriate for all settings and circumstances. Forms of this nature must be reviewed for applicability to each particular case and appropriate modifications must be made. Federal and state laws and regulations for professional credentials may have different requirements. Revisions may need to occur to satisfy HIPAA requirements. Limits of confidentiality and protection of privacy may need to be readdressed. Consent forms directed to more than one party should be avoided.