Road 2 Resolutions PLLC
Professional Counseling

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CONSENT TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (HM) _____(WK) _____ Date of Birth: _____

I, _____, authorize ***Ugochukwu Uche, M.S., L.P.C.*** to: *(PLEASE MARK ALL THAT APPLY)*

- ☐ **OBTAIN**
- ☐ **RELEASE**

Medical, psychological, educational, legal and social information pertaining to the above mentioned individual.

Person / Agency / Institution, from or for who records are to be obtained / released:

Name:_____

Phone Number:_____

Address:_____

_____

Purpose of obtaining / releasing information: _____

_____

Information to be obtained / released:

- ☐ Assessment Information
- ☐ Treatment Plan(s)
- ☐ Progress Notes
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Other: _____

This release shall be effective for one year, until the _____day of_____, 20_____.

Ugochukwu Uche, M.S., L.P.C. is hereby released from any and all legal liability that may arise from the obtention or release of the information requested. I certify that this request for obtention or release has been made freely and voluntarily. I understand that I may revoke this authorization at any time, except that action has already been taken on the consent.

I understand that my records are protected under federal regulations 42 CFR Part 2, governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance on it, and that in any event this consent expires automatically in one year from the time this form is signed.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____