CORAL COUNSELING CENTER

Authorization to Release Information

I hereby authorize **Coral Counseling Center**

_____ to release

_____ to obtain

The following information: _____

_____

- if obtaining other records we need approximate dates and description of records

To/From: _____

Address: _____

_____

Regarding: _____ ____/____/_____

(Name of client) (Date of Birth)

_____ _____/_____/_____

(Maiden/Previous Name) (Social Security Number)

I understand that my medical records may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information. I understand that once information has been released to the above named party, my information may be subject to re-disclosure. I understand that I do not have to sign this authorization, and services will not be denied if I do not sign this form. I understand to the extent that action has not already been taken in regard to this authorization, that I may revoke this authorization by submitting notice in writing to the facility privacy officer at 313 South Ave Suite 401 Springfield, MO 65806.

CORAL COUNSELING CENTER

The previous information is to be released for the purpose of _________________

____

and for this purpose only.

Unless revoked this authorization expires on: ____/____/_____.

Signature:___________________________________ Date:____/____/_____

(Of Client or Parent/Guardian)

Signature:________________________________ Relationship:____________ __

(Of Witness)

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