

RELEASE/EXCHANGE OF INFORMATION CONSENT FORM

From the counseling office of Vickie Purdy, LPC

(361) 494-4171

vickiep@vickiepurdy.com

I, _____, date of birth: _____, authorize and give written consent to Vickie Purdy, MS, LPC and/or licensed subcontractors to release and disclose, in accordance with HIPAA standards, to:

_____ and staff, including in particular: _____

Information regarding my case, including comprehensive intake assessments, detailed progress notes, on-going assessments, on-going recommendations, treatment plans, closing summaries via secure email, telephone calls, or mail.

Name of Individual/Agency: _____

Address: _____

Phone number: _____

Email: _____

This information is used to review progress and assess need for continued services. I understand that my records are protected by federal and state confidentiality regulations 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 action has been taken in reliance on it. In any event, this consent is effective for a period of:

3 months _____

6 months _____

12 months _____

Client Signature: _____ Date: _____

Parent/Guardian relationship: _____ Date: _____

Witness signature: _____ Date: _____