

Kuna Counseling Center
190 W. Main, Kuna, Idaho 83634
(208) 922-9001

Request for Release of Confidential Information

Client: _____ Date of Birth: _____

Client: _____ Date of Birth: _____

Client: _____ Date of Birth: _____

The undersigned, clients, parents, or legal guardians request:

SPECIFIC TYPE/EXTENT OF INFORMATION TO BE DISCLOSED: _____

I understand that this information may be sent by fax, mail or telephone. _____

To/From: <u>Jim A. Grigg, LCPC, LMFT</u> <u>Kuna Counseling Center</u> <u>190 W. Main St.</u> <u>Kuna, Id. 83634 (208) 922-9001</u>	From/To _____ _____ _____ _____
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PURPOSE OR NEED FOR THIS DISCLOSURE: _____

I have carefully read, and understand, the foregoing. I voluntarily consent to the release of the above specified information about or medical records of my condition and the treatment and services I have received to those persons or agencies listed. I further release my counselor from any liability arising from the release of this information or records to such designated persons or agencies. This consent is subject to revocation at any time and unless otherwise specified expires six months (180 days) after date of signing.

_____, Signature	_____, Signature
_____, Signature	Date: _____

Witness: _____ Date: _____
 (parent, guardian, or authorized representative of client)

NOTE TO AGENCY/PERSON IN RECEIPT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CRF Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.