Creative Counseling & Learning Solutions, PLLC

Request/Authorization to Release Confidential Records and Information

I hereby authorize the release of information from my records to/from _____ (address): _____ (phone): _____ to/from Creative Counseling & Learning Solutions, PLLC Address: PO Box 81 Badin, NC 28009 Phone: 704-422-5964 for the following purposes ☐ Further mental health evaluation, treatment, or care ☐ Rehabilitation Program ☐ Treatment Planning ☐ Research ☐ Court proceedings ☐ Other: _____. These records concern the time between _____ and _____.

Please select the information to be disclosed: ☐ Intake and discharge summaries ☐ Medical history & evaluations ☐ Mental health evaluations ☐ Developmental history ☐ Educational records ☐ Progress notes, treatment or closing summary ☐ Other: _____.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless directed here: ☐ Do NOT release HIV-related information ☐ Do NOT release drug and alcohol information

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of the release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

Client's Signature: _____ Printed name: _____

If Client is a Minor, Parent's/Guardian's Signature: _____

Printed name of Parent/Guardian: _____ Date: _____