

**CONSENT FOR RELEASE/ EXCHANGE OF INFORMATION**

Name (Printed) \_\_\_\_\_

Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

Phone Number \_\_\_\_\_

I hereby authorize a representative from:

**Pemberton Counseling Services, PSC      1700 UPS Dr. Suite 107, Louisville, KY 40223**  
**Phone – 502-327-8045      Fax 502 – 327-7227**

to release/exchange information with the below named person/agency/healthcare provider:

Name/Agency \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**It is acknowledged that this is a reciprocal agreement and permission is given to both parties to exchange information.**

Information Needed:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> All Records       | <input type="checkbox"/> Course of Treatment | <input type="checkbox"/> Psychological Evaluations            |
| <input type="checkbox"/> Telephone Contact | <input type="checkbox"/> Hospital Stay       | <input type="checkbox"/> Social History                       |
|  | <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Alcohol/Drug Treatment & Assessments |
|  | <input type="checkbox"/> Termination Summary | <input type="checkbox"/> Mental Health Services & Assessments |
|  | <input type="checkbox"/> School Records      | <input type="checkbox"/> Lab/EKG                              |

Other \_\_\_\_\_

\*\*\*\*\*  
As the person signing this consent, I understand that I am giving my permission to the above named provider or other named third party for disclosure of confidential health records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and notation concerning the person or agencies to whom disclosure was made will be included with my original records. The person who receives records to which the consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law. I understand that the information to be released may contain information from other providers, confidential information, information related to drug/alcohol abuse/treatment and/or psychiatric mental health information. I authorize the release of the information.

\_\_\_\_\_  
Patient Signature Date

Parent/Legal Guardian

_____ Printed	_____ Signature
_____ Contact phone number	_____ Date of release

Consent expires 1 year after today's date unless another date is specified \_\_\_\_\_