PURPOSE DRIVEN COUNSELING SERVICES, LLC
AUTHORIZATION TO RELEASE AND OBTAIN CONFIDENTIAL INFORMATION

Client Name: ____ Date of Birth: _____________

I hereby authorize (therapist name): Daniel J. Bernhardt, MS, LPC to receive ( ) and/or to release ( ) information obtained in the course of the diagnosis and treatment of the above named client for mental health purposes from/to:

Name of Individual/Agency/Facility (you want your information released to or collected from):
____

Phone:____ Fax:________________________________

Address:____

City:_______________________________________ State: _______ Zip Code: ___________________

This authorization releases Purpose Driven Counseling Services, its owner and any of its employees or independent contractors from any legal responsibility or liability for the disclosure of the following information to the extent indicated and authorized herein. In accordance with Federal Regulations 42 CFR Part 2, I hereby consent to the release of records pertaining to diagnosis and treatment of the following: (If client is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the client and the parent/guardian must sign.)

Yes ( ) No ( ) Conditions related to drug and/or alcohol abuse
Yes ( ) No ( ) Conditions related to psychiatric/psychological treatment
Yes ( ) No ( ) Intake evaluation, diagnosis, recommendations
Yes ( ) No ( ) Progress notes, staffing notes, group notes
Yes ( ) No ( ) Lab reports or medical testing results
Yes ( ) No ( ) Other ____
Yes ( ) No ( ) No records. Two-way communication only for above marked items

I understand I may revoke this consent at any time and that upon fulfillment of the above stated purpose, this consent will automatically expire one (1) year following date of signature without my expressed revocation.

I understand that the release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written authorization must be obtained for a proposed new use of the information or for its transfer to another person or entity. I understand that I have the right to receive a copy of this authorization if I so request.

____ ____________________
Patient Signature Date

____ ____________________
Parent/Guardian Signature Date

____ ____________________
Witness Date