



Carbon-Monroe-Pike Mental Health and Developmental Services

Tina L. Clymer, MS, LPC, Administrator

CONSENT TO OBTAIN OR RELEASE INFORMATION

Client _____ Date of Birth _____

Social Security # _____ Base Service Unit # _____

I hereby authorize Carbon-Monroe-Pike MH/DS Program to obtain [] from / [] release to

(Person / Facility/Address)

information for the purpose of _____

The information to be obtained/released, relating to the period of time between _____
and _____ consists of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Past & present psychiatric /medical history | <input type="checkbox"/> Social history | <input type="checkbox"/> Mental status exam |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Neurological consults | <input type="checkbox"/> Neurological testing |
| <input type="checkbox"/> Laboratory results | <input type="checkbox"/> EKG results | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> School records | | |

[] Other _____

This consent is effective from (date) _____ to (date or event of expiration)
_____ (not to exceed one year).

I have been told in order to protect confidentiality of records, my agreement to obtain or release information is necessary, and that this permission is limited for the purpose and to the person or organization listed on this form. I understand that I may withdraw my permission for release of information at any time, and that I have the right to a copy of this release.

Consumer / Date
(or parent or guardian under 14yrs of age)

Witness / Date

The foregoing person who is unable to provide a signature, freely gave a verbal consent to the release of information requested. He/she had the request read to him/her and understands the nature of the release. He/she also understands that this consent may be orally revoked at any time.

Witness / Date

Witness / Date