Break Thru Counseling Center
4012 Katella Ave., Suite 205
Los Alamitos, CA 90720
(562)431-1799

Consent to Release Client Records/Information

Name of Client:_____ Date of Birth:_____

Address: _____

I hereby authorize the following specified individual(s) or organization to **exchange** records or information with _____, my counselor at Break Thru Counseling Center. This authorization is limited to information concerning myself which has been acquired in a professional capacity and which may be deemed necessary for the purpose of assessment, treatment, or insurance payment.

Examples of specified individuals or organizations:

- For a specified physician, psychologist, counselor, or mental health facility I authorize release of any medical or psychological records or information.
- For a specified school and any teacher, counselor, or administrator thereof, I authorize release of records or information regarding my school attendance, academic performance and behavior as well as pertinent test results.
- For a specified insurance carrier I authorize disclosure of myself as a client, diagnosis, treatment dates, treatment plan, treatment cost, and progress reviews.
- For a specified pastor, family member, or friend I authorize exchange of information that may be pertinent to my treatment, safety, and emotional well-being.

_____ _____
Name of Individual or Organization Phone Number

_____
Address

_____
City State Zip

This consent may be revoked by the undersigned by providing written notice.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date