Hamilton Professional Counseling
970 Logan Street, Suite 213
Noblesville, IN 46060

Release of Information

Client Name	Date of Birth	Record No.	
Street Address	City	State IN	Zip

I hereby authorize Hamilton Professional Counseling to : (Check appropriate boxes)

Information to be Released / Obtained	**Release To**	**Obtain From**	**Dates or Description of Info. Requested**
Treatment Plan			
Client Profile / Admission Assessment			
Medication Record			
Psychiatric Evaluation Report			
Psychological Testing Results			
Discharge Summary			
School Records			
Reports (Court, DCS, Probation, School, Voc. Rehab.)			
Medical Records			
Drug and/or Alcohol related information			
Informal communication			
Other:			

A separate authorization must be obtained for each individual or agency. Please specify the name of the individual or agency to receive the information.

Name of Individual or Agency to Release To / Obtain From:	Phone # (optional)
Address	City, State, Zip

Information that has been released is no longer protected by Hamilton Professional Counseling and may be subject to re-disclosure by the recipient, even though further disclosure of this information is prohibited unless permitted by the written authorization of the client, or their parent, guardian, or personal representative. A copy of this authorization shall be as valid as the original.

For the purposes of _____
(State specific purpose of information to be disclosed)

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Hamilton Professional Counseling.. I understand that a revocation is not valid to the extent that Hamilton Professional Counseling has acted in reliance on such authorization. This authorization is valid until _____ or 60 days past termination of services at Hamilton Professional Counseling.

A copy of this release shall have the same force and effect as the original.

_____ _____ _____ _____
(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

_____ _____ _____
(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.