the Center
for Christian Counseling, Consultation & Training, Inc.

5310 Wall Street, Ste 500
Madison, WI 53718
608.274.8294
608.274.8783 Fax

CONSENT FOR RELEASE OF INFORMATION - PASTORAL

I, _____(client), hereby authorize _____(therapist)

at The Center for Christian Counseling, Consultation and Training Inc. at 5310 Wall Street, Suite 500 Madison, WI

To: (Please Check Appropriate Choice) _____ RELEASE INFORMATION TO:
_____ OBTAIN INFORMATION FROM:
_____ EXCHANGE INFORMATION WITH:

NAME: _____ / _____
(pastor) (church)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ - _____ FAX: (_____) _____ - _____

INFORMATION REGARDING: _____ _____ / _____ / _____
(Print first and last names) (Date of Birth)

Indicate Maiden Name or Previous Name(s) Used: _____

Purpose or Need for Disclosure: (check those that apply)

____Treatment planning ____ Treatment coordination ____ Consultation ____ Other: (specify) _____

Specific Information Requested: (check those that apply)

____ Treatment summary ____ Progress notes ____ Psychological Testing ____ Discharge Summary ____ AODA Evaluation

____ Assessments ____ Other (_____)

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: _____

I understand that I may revoke this authorization to release information at any time by giving written notice to the releasing person/agency. I further understand that any information released while this consent is in force cannot later be retrieved and that the releasing organization cannot be held responsible for any such release.

This authorization expires on _____, or one year from today.

SIGNATURE OF CLIENT: _____ DATE _____

SIGNATURE OF AUTHORIZATION PERSON: _____ DATE _____

If signed by person other than client, state authority to do so below:

____ Legal Authority ____ Legal Guardian ____ Parent of Minor ____ Next of Kin

SIGNATURE OF THERAPIST _____ DATE _____

According to Wisconsin Administrative Code HSS 92.05, the client has a right to inspect and receive a Copy of the material to be disclosed. This authorization form is in conformance with Title 42, "Code of Federal Regulations, "Sections 2.1 through 2.67.

No information released to The Center for Christian Counseling, Consultation and Training, Inc. will be re-released to any other person or agency.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, The Center for Christian Counseling, Consultation and Training, Inc. providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.