



CONSENT FOR RELEASE AND/ OR RETRIEVE OF INFORMATION

If consultation is requested and information is to be exchanged between Brad Graham, M.Ed. and a third party, the name, address and phone number of the designated third party should be listed in both the RELEASE and RETRIEVE sections below.

Purpose: _____

RELEASE: I hereby consent to Brad Graham, M.Ed. to *release* information to the following parties. This includes written and verbal transfer of history, as well as mental health treatment information for the purpose of consultation and coordination and relevant professionals.

I wish to release: [] Confirmation and dates of sessions [] Diagnosis [] Written summary of treatment [] Other: _____

Limitations, if applicable: _____

Name: _____ Address: _____
Phone/ Fax #: _____ Email: _____

RETRIEVE: I hereby consent to Brad Graham, M.Ed. to *retrieve* information from the following parties. This includes written and verbal transfer of history, as well as mental health treatment information for the purpose of consultation and coordination and relevant professionals.

I wish to retrieve: [] Confirmation and dates of sessions [] Diagnosis [] Written summary of treatment [] Other: _____

Limitations, if applicable: _____

Name: _____ Address: _____
Phone/ Fax #: _____ Email: _____





CONSENT FOR RELEASE AND/ OR RETRIEVE OF INFORMATION

AUTHORIZATION: I certify that this authorization to release and/or retrieve has been made voluntarily. I understand the information to be released and/or retrieved may include information related to substance abuse, family or medical history, diagnosis, and other information discussed during the course of counseling.

I understand that I may revoke this authorization at any time by giving written notice except in the extent that action has already been taken on this request. This authorization will expire in six months from the date treatment is terminated.

Name of Client (or Guardian)

Signature of Client (or Guardian)

Date

