ISU-POCATELLO COUNSELING CLINIC
Department of Counseling
1400 E. Terry Dr., Bldg. 68, Pocatello, ID 83209
(208) 240-1609

Release of Information

Patient Name: _____ **DOB:** _____

I authorize the ISU Counseling Pocatello Clinic to disclose to and/or obtain information

from: **Name:** _____
Address: _____
_____
Phone: _____ **Fax:** _____

Description of Information to be Disclosed (check all that apply):

- ☐ Initial Assessment
- ☐ Treatment Plan or Summary
- ☐ Treatment Notes
- ☐ Continuing Care Plan
- ☐ Recommendations for Support

Other:
_____

The purpose of this disclosure is for (check all that apply):

- ☐ Continuity of Care
- ☐ Acknowledgment of Care
- ☐ Recommended Support to Client
- ☐ Referral for Ongoing Treatment

Other: _____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the ISU Pocatello Counseling Clinic. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

The doctrine of consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is voluntary and expires one year from the date of this authorization or sooner upon my request. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

I have read, understand, and agree to the information above.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature if client under 18 Date