Pathway Counseling Ministry

P.O. Box 620478
Oviedo, FL 32762-0478
Phone: 407-366-5656/ Fax: 407-386-6658

Authorization To Release Or Exchange Information

Client Name: _____ DOB: ____/ ____/ _____

Therapist: _____ Location: _____

Information to Be Released By Or Exchanged With:

Name: _____ Title: _____

Address: _____ _____

City: _____ E-mail: _____

State: _____ Zip Code: _____

Phone: ( ) _____ - _____ Fax #: ( ) _____ - _____

Information To Be Released Or Exchanged:

- ☐ History and Physical Exam
- ☐ Family Systems Evaluation
- ☐ Mental Status
- ☐ Psychiatric Evaluation
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Chemical Recovery History
- ☐ Educational Tests & Reports
- ☐ Diagnoses
- ☐ Attendance Record
- ☐ Medical Records
- ☐ Clinical Summary
  *To include diagnosis, attendance, progress update, & treatment plan
- ☐ Court/ Agency Documents
- ☐ Discharge Summary
- ☐ Nursing Notes
- ☐ Treatment Plans
- ☐ Psychological Test Results
- ☐ Educational Records
- ☐ Therapist Orders
- ☐ Dates of Hospitalizations
- ☐ Crisis Intervention Reports
- ☐ Psychosocial Report
- ☐ Lab Results
- ☐ Other: (specify)
  _____
  _____

By Signing below, I, _____, authorize Pathway Counseling Ministry to release and/or exchange information with the individual(s)/ organization(s) listed in this document:

_____ _____/_____/_____

Client Signature Date

Information contained in this document is CONFIDENTIAL.