Odyssey Counseling
Let us help you put your life back together

RELEASE OF INFORMATION

I, _____, hereby authorize Odyssey Counseling, or its designee

_____ to obtain AND/OR release information to:

_____.

The information to be shared is:

___ Diagnosis
___ Drug/alcohol history
___ Treatment summary
___ Attendance
___ Mental status exam
___ Evaluation/assessment
___ Progress
___ Recommendations
___ Discharge summary
___ Prognosis
___ Other:

The purpose for such disclosure is:

___ Continuity of care
___ Aftercare planning
___ Family involvement
___ Referral
___ Contact with referring professional
___ Other:

This consent is subject to revokation at any time, but must be done so in writing by client. Consent will automatically expire one year from the date of signature.

_____ _____
Client Name Date

_____ _____
Client/Parent/Guardian Signature Date

_____ _____
Witness Signature Date

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