Kindred Counseling Center
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**Doylestown**
350 S. Main St.
Suite 306
Doylestown, PA 18901

**Philadelphia**
401 S. 2nd St.
Suite 401
Philadelphia, PA 19147

# Release of Information Consent Form

I, _____ (Client), authorize **Kindred Counseling Center** to:

- ☐ receive information and/or
- ☐ release **any** information regarding my case
- ☐ release information regarding only the following: _____

This information may be exchanged as indicated above with the following:

_____
Name (Agency/Contact Person)

_____
Street Address, City, State, Zip

_____ _____
Phone Number Fax Number

Purpose:

- ☐ To improve assessment & treatment planning, share info relevant to treatment, and coordinate treatment services when appropriate.
- ☐ Plan for and provide referral, assessment, ongoing treatment or medical care.
- ☐ To obtain insurance, employment, social services, or government benefits.
- ☐ To enable judges, attorneys, and/or probation/parole officers to support treatment or make legal decisions on my (or my child's) behalf.
- ☐ To coordinate treatment with my family or concerned person or agency.
- ☐ To coordinate treatment with my school, employer, or EAP representative.
- ☐ Other: _____

I understand that by law, I do not need to consent to this release of information. I do so willingly and voluntarily for the purpose(s) specified above. The duration of this consent will be for one year or at case closure, whichever comes first. I understand that I may revoke this consent at any time, except to the extent that action has already been taken. I understand that I am entitled to a copy of this document. I certify that this document has been explained to me and that I understand its contents.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name (Client or Parent/Guardian) | Signature of Client | Date |
| _____ | _____ | _____ |
| Printed Name, Age (Minor) | Signature of Minor | Date |

***This is a strictly confidential client record. Redisclosure or transfer is expressly prohibited by law.***