



141 Discovery Dr. Suite 213 | Bozeman, MT 59718 | gocmt.org

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

The purpose of this form is to allow your individual counselor and group leader to communicate freely about any areas of your mental health you feel pertinent.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

I hereby authorize the release of the following specific information (please check all items):

- | Yes | No  |  |
|-----|-----|--|
| ___ | ___ | 1. Medical history, examination, laboratory tests and treatment reports                      |
| ___ | ___ | 2. Psychological test reports  |
| ___ | ___ | 3. Psychiatric evaluation reports  |
| ___ | ___ | 4. Social history data, including family, education, employment and other relevant materials |
| ___ | ___ | 5. Summary of current and/or previous mental health treatment                                |
| ___ | ___ | 6. Periodic reports of current treatment progress, including attendance and participation    |
| ___ | ___ | 7. Notification of referral source of initiation and termination                             |
| ___ | ___ | 8. Specify: _____  |

From/To: Great Oaks Counseling Center

From/To: \_\_\_\_\_  
(Name of agency or individual)

\_\_\_\_\_  
(Address) (City) (State/zip)

I understand this information will be used for the following specific purposes (please check all items):

- | Yes | No  |  |
|-----|-----|--|
| ___ | ___ | 1. To coordinate care between individual and group counseling  |
| ___ | ___ | 2. If desired, to coordinate care between my group coordinator, individual counselor, and group leader |
| ___ | ___ | 3. To develop a diagnosis, treatment and rehabilitation plan   |
| ___ | ___ | 4. To coordinate medical, psychological and social rehabilitation processes                            |

I understand no information may be released by either agency to any other agency or individual unless by my written consent. This authorization may be revoked at any time by my written statement, and it is automatically revoked at the end of treatment unless otherwise specified.

This consent for the release of information is given freely, voluntarily and without coercion.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date