All Things Are Possible
Community Counseling Services

Release of Information Form

Client Name: _____ DOB: _____

RELEASE TO:

_____

_____

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_____

I, the undersigned, do hereby consent and agree that **All Things Are Possible Services, LLC** and the addresses to exchange the information designated below. This information is to be kept confidential and may not be released to any other agency without my consent. The purpose of this release is to provide continuity of care and to assist in planning and providing services to me. In no way will this information be used to discriminate against me or deny me services.

I allow verbal exchange between **All Things Are Possible Services, LLC** and addresses as well as the following information:

____ Demographic Information
____ Intake Assessment
____ Individual Treatment Plan & Reviews
_____ Psychiatric Evaluation
_____ Psychological Evaluation
_____ Medication Record
_____ Entitlement Information
_____ Physical Examination Results
_____ Transfer/Discharge Summary
_____ Immunization Records
_____ Physician's Recommendations
_____ Other _____

_____
Client or Guardian Signature Date

Intake Personnel Signature/Credentials Date

Date Consent Expires: A Year from Date Signed