

# CHRISTIAN COUNSELING ASSOCIATES, Inc.

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## Authorization for Providing and/or Receiving Protected Client Information

Name and address of sending/receiving \_\_\_\_\_  
organization or individual: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby authorize release of the following information about me or about my child or ward **to** and/or **from** Christian Counseling Associates, Inc., by verbal, written or electronic means:

Psychiatric Evaluation                       Laboratory Reports  
 Psychological Evaluation                     Intake/Discharge Summaries  
 Social History                                     Entire Record  
 Educational Diagnosis                         Other (specify)

Date \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

\_\_\_\_\_ I authorize the release of the above-described information from Christian Counseling  
(initials) Associates, Inc., to the above-named organization or individual.

\_\_\_\_\_ I authorize the release of the above-described information from the above-named  
(initials) organization or individual to Christian Counseling Associates, Inc.

I understand that Christian Counseling Associates, Inc., cannot be held responsible for redisclosure of protected health information once it has been released to another party. I also understand that I may revoke or terminate this authorization by submitting a written request to the Executive Director of Christian Counseling Associates, Inc.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or  
Guardian (in case of a minor) \_\_\_\_\_ Effective Thru \_\_\_\_\_

Witness \_\_\_\_\_

Our Staff Members are Committed Christians and Fully Trained Professionals