



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