genesis
COUNSELING CENTER

Specific Consent for Release/Exchange of Information

This consent applies to: _____ DOB: _____
(Client) (Client's date of birth)

I hereby give my informed consent for GENESIS COUNSELING CENTER to talk with and/or release written documentation regarding my treatment to: (Please print)

___ **Primary Care Physician/ Psychiatrist**: _____
Name, address, and phone number of person or organization

Except for the following information:

___ **Church or Minister**: _____
Name, address, and phone number of person or organization

Except for the following information:

___ **Probation Officer**: _____
Name, address, and phone number of person or organization

Except for the following information:

___ **Case Worker or Social Worker**: _____
Name, address, and phone number of person or organization

Except for the following information:

___ **Spouse or other family member**: _____
Name, address, and phone number of person or organization

Except for the following information:

___ **Other**: _____
Name, address, and phone number of person or organization

Except for the following information:

_____ _____
Client or Guardian Signature Date

_____
Signature of Witness

Updated 4/2016