Clinical Counseling Services of Cincinnati
4055 Executive Park Drive, Suite 210
Cincinnati, OH 45241
513-469-6226

CONSENT FOR RELEASE OF MEDICAL/CLINICAL INFORMATION

I,_____, _____ hereby authorize
(Print client name) (DOB)

_____ to disclose the following information:
(Name of clinician)

_____

_____

_____
(State nature and extent of information to be disclosed and records to be released).

Information will be released to the following person(s) or organization(s):
_____.
(Title and name of person)

This consent is valid for 1 year from the signature date. Consent is subject to my revocation at any time except to the extent an action has already been taken.

_____ _____
Client Signature Clinical Counseling Services Signature

_____
Signature of Parent/Legal Guardian

_____
Date

The information, which is being disclosed, is from records whose confidentiality is protected by Federal Law. Federal Regulations (42-CRF Part 2) prohibit disclosure without the specific concern of the person to whom it pertains. A general authorization is not sufficient for such release.