

SHEPHERD'S STAFF CHRISTIAN COUNSELING CENTER
731 East 8600 South, Sandy, UT 94094 801-561-9987

Authorization For Release of Information

I, _____, do hereby consent to and authorize _____ or administrative/clerical staff of Shepherd's Staff Christian Counseling Center to disclose to/receive from: (specify name and address) _____

I understand that the specific information from my client record(s) to be disclosed includes: _____

and that the purpose or need for this disclosure is to: (specify reason for disclosure) _____

I understand the right to revoke this authorization, in writing, at any time. Specific exceptions and instruction on how to revoke are identified in the current SSCCC Notice. However, my revocation will not be effective to the extent that SSCCC has taken action in reliance on the authorization. I understand that SSCCC may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.

This consent shall begin _____ and end _____.

Client's full name (please print)

Client's signature (parent/guardian of minor)

Client's Birthdate

Relationship to Client

Signature of Witness

Date

THIS PORTION TO BE COMPLETED WHEN A CLIENT IS UNABLE TO GIVE WRITTEN CONSENT

We, the undersigned, do verify that the above authorization has been read to the client and that he/she understands the nature of the release and freely gives his/her verbal consent for release of information.

Signature of Responsible Witness

Date

Signature of Responsible Witness

Date