

METTA COUNSELING SERVICES, LLC

Baxter Village Location  
1012 Market Street, Suite 305  
Fort Mill, SC 29708

**CONSENT FOR USE, DISCLOSURE AND/OR RELEASE  
OF PERSONAL AND HEALTH INFORMATION**

INFORMATION:

LAST NAME	FIRST NAME	MIDDLE NAME	Date of Birth
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ADULT INFORMATION:

ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER
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**I. PERSON OR AGENCY REQUESTING THE INFORMATION:**

The persons or agency can request my personal, health, and/or mental health information: (The information to be released is described in Section III below.)

Agency Name:

Address

City, State, Zip Code:

Agency Contact and Title:

Telephone No.:

**II. PERSON OR AGENCY PROVIDING THE INFORMATION:**

The persons or agency may release my personal, health, and/or education information: (The information to be released is described in Section III below.)

Agency Name:

Address:

City, State, Zip Code:

Agency Contact and Title:

Telephone No.:

**III. INFORMATION THAT MAY BE RELEASED:**

The persons or agencies marked in Section IV below may view, copy, release and exchange the information or records marked below *(please check all that apply to your child's needs now and in the future)*. This information may be shared verbally, in writing, and/or by email or fax:

- |  |   |
|--|---|
| <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> Family Information, including but not limited to size of family. |
| <input type="checkbox"/> Treatment Planning        | <input type="checkbox"/> Anger Management Treatment/Group                                 |
| <input type="checkbox"/> Diagnosis                 | <input type="checkbox"/> Assessment/Screening   |
| <input type="checkbox"/> Other:                    | <input type="checkbox"/> Medication Evaluation  |

**SPECIFIC AUTHORIZATIONS:**

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- I specifically authorize the release of information pertaining to mental health diagnosis or treatment or psychological information (Welfare & Institutions Code, §§5328, et seq)

**MY INFORMATION MAY BE USED TO:**

1. Get more services for myself.
2. Allow various professionals to understand my treatment.
3. Allow various professionals to help coordinate medical and non-medical services.

**IV. INFORMATION MAY BE EXCHANGED BY THE FOLLOWING PERSONS OR AGENCY(IES):**

I agree to sharing with agencies marked below *(Please check all that apply to your child's needs now and in the future.)*:

<input type="checkbox"/> <b>Mental Health Services</b> <input type="checkbox"/> Psychologist <input type="checkbox"/> Physician/Psychiatrist <input type="checkbox"/> Therapist <input type="checkbox"/> Social Worker <input type="checkbox"/> Case Manager <input type="checkbox"/> Other _____	<input type="checkbox"/> <b>School District (specify:_____)</b> <input type="checkbox"/> Teacher <input type="checkbox"/> School Psychologist <input type="checkbox"/> School Counselor <input type="checkbox"/> School Administrator <input type="checkbox"/> Speech/Language Therapist <input type="checkbox"/> School Nurse <input type="checkbox"/> Other:_____
<input type="checkbox"/> <b>Social Services Agency</b> <input type="checkbox"/> Social Worker <input type="checkbox"/> Case Manager <input type="checkbox"/> Other:_____	<input type="checkbox"/> <b>Healthcare Services</b> <input type="checkbox"/> Primary Health Care Provider <input type="checkbox"/> Physician Specialist <input type="checkbox"/> Social Worker <input type="checkbox"/> Psychologist <input type="checkbox"/> Family Support Worker <input type="checkbox"/> Other:_____
<input type="checkbox"/> <b>Regional Centers</b> <input type="checkbox"/> Service Coordinator <input type="checkbox"/> Administrative Staff <input type="checkbox"/> Family Support Worker	<input type="checkbox"/> <b>Family Resource Center</b> <input type="checkbox"/> Case Manager <input type="checkbox"/> Administrative Staff <input type="checkbox"/> Family Support Worker
<input type="checkbox"/> <b>Early Care and Education Center Program</b> <input type="checkbox"/> Teacher <input type="checkbox"/> Staff <input type="checkbox"/> Child Caretaker <input type="checkbox"/> Other	<input type="checkbox"/> <b>Other Agency: _____</b>

**VOLUNTARY:** I know that I do not have to sign this consent form. I can refuse to sign this consent form, and it will not affect the services I receive from any of the agencies.

**LENGTH OF TIME:** This consent will be valid from the date that I sign this form until \_\_\_\_\_(date). If no date is entered, the form will be valid for one year after the date that I sign the form.

**WITHDRAWAL:** I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section I. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I signed the consent form.

**SHARING OF INFORMATION:** I know that my information may be shared more than once by the persons and/or agency's in Sections I and II. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws.

**COPY:** A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent form if I ask for one.

Signature:	Date:
Relationship to patient:	