



### Consent for Communication, Consult, Release of Information

I, (print name) \_\_\_\_\_ hereby authorize Verone M. Travis, MA, LPC Intern, Christian Counseling Associates, providing therapy services in connection with my treatment, to contact or consult with:

Professional	Name	Phone Number/Email
<input type="checkbox"/> Counselor	_____	_____
<input type="checkbox"/> Psychologist	_____	_____
<input type="checkbox"/> Psychiatrist	_____	_____
<input type="checkbox"/> Family Physician	_____	_____
<input type="checkbox"/> School Counselor	_____	_____
<input type="checkbox"/> Pastoral Counselor	_____	_____
<input type="checkbox"/> Other ( )	_____	_____

Purpose of contact is to (check one or both):

**DISCLOSE** information to AND/OR  **OBTAIN** information below as indicated by my initials:

- |  |   |
|--|---|
| <input type="checkbox"/> Coordination of care with PCP     | <input type="checkbox"/> Diagnosis/assessment                 |
| <input type="checkbox"/> Attendance records                | <input type="checkbox"/> Progress report on my counseling     |
| <input type="checkbox"/> Prognosis                         | <input type="checkbox"/> Results of mental status examination |
| <input type="checkbox"/> Drug/alcohol history              | <input type="checkbox"/> Treatment recommendations            |
| <input type="checkbox"/> Results of Drug/Alcohol Screening | <input type="checkbox"/> <i>Other (specify)</i>               |
| <input type="checkbox"/> Discharge summary                 | _____   |

I, \_\_\_\_\_, release my counselor, Verone M. Travis, to contact the above professionals from whom I am currently receiving services.

\_\_\_\_\_  
Client Date

\_\_\_\_\_  
Client Date

\_\_\_\_\_  
Counselor Date