Release

Boise Counseling Center

Consent to Release and/or Obtain Records and Information

Client Name _____

Social Security Number or Birth Date _____

The client authorizes **Victor Durnil,** LCPC, CSAT of Boise Counseling Center, LLC in Boise, Idaho, to release records and information to, and obtain records and information from, the authorized person(s) and/or organization identified below, for the purpose of continuing counseling, treatment, and referral.

Authorized person(s) and/or organization _____

Relationship to Client _____ Phone _____

_____

Address City State Zip

The information to be disclosed is:

☐ All treatment records and information in the possession of the authorized person(s) and/or organization named in this release.

☐ Other (specify) _____

_____

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient. Photocopies or facsimile of this Authorization shall be considered to be the same as a signed original document. I understand that certain records may be protected from disclosure without my written consent or as otherwise authorized by law under provisions of State and Federal law, including Federal statutes and regulations governing confidentiality of drug and alcohol records (42 CFR part 2.)

X _____
Print Client Name

X _____
Signature of Client and Parent or Legal Guardian, if client is under 18 Date

X _____
Print Name of Parent or Legal Guardian, if client is under 18

_____
Witness Date

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