FAIRVIEW COUNSELING
OF CHESTER COUNTY

CONSENT TO DISCLOSE OF CLIENT RECORDS/ INFORMATION

Client Name: _____ Date of Birth: _____
Client Address: _____
Phone Number: _____

I, _____, authorize Fairview Counseling of Chester County to disclose/release records to:

_____
_____
(name, address, phone number of person/organization to whom information will be released)

I, authorize release of the following information:

_____Diagnostic summary
_____Treatment summary
_____ Progress notes
_____ Other: _____

I understand that this information is being released for the following reasons:

_____Facilitation of assessment _____ Coordination of treatment and support
_____ Legal Reasons _____Monitoring Progress
_____ Other: _____

I understand that I may revoke this release at any time. In the event that this release remains in effect, it will automatically expire one (1) year from the date signed below.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian if Client is under 18 Date

_____ _____
T. Danielle DiNatale, LCSW Date