Care & Counsel, SC
15350 West National Avenue, #109
New Berlin, WI 53151
262-797-7979

Consent for Release of Information

I, the undersigned, hereby consent to the disclosure of the information specified below concerning:

I, _____, _____, _____, _____
(Patients First Name) *(Middle Name)* *(Last Name)* *(Date of Birth)*

I hereby request and authorize:	**I hereby request and authorize:**
Care & Counsel, SC **15350 West National Avenue #109** **New Berlin, WI 53151**	**Name:** _____ **Address:** _____ _____ **Phone #:** _____
To Release Information To: **Name:** _____ **Address:** _____ _____ **Phone #:** _____	**To Release Information To:** **Care & Counsel, SC** **15350 West National Avenue, #109** **New Berlin, WI 53151**

Please check the appropriate boxes.

For the Purpose or need:

☒ Evaluation and treatment

☐ Other (specify): _____
_____
_____

The disclosure of the following specific information is authorized:

☒ Any and all information related to the above named person(s)

☐ Other (specify): _____
_____
_____

This consent shall remain in effect until: _____ or until revoked in writing.

_____ _____ _____
(Signature of Patient or Personal Representative) *(Relationship)* *(Date)*

Attention: _____