GENTLE SHEPHERD COUNSELING CENTER
1469 SOUTH MAIN STREET
NORTH CANTON, OH 44720
PHONE: 330.499.3065
FAX: 330.499.2497

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Home #: _____ Cell #: _____

I CONSENT AND REQUEST GENTLE SHEPHERD COUNSELING CENTER TO:

☐ RELEASE INFO TO: ☐ OBTAIN INFORMATION FROM: (PLEASE CHECK ONE OR BOTH)

FACILITY: _____ INDIVIDUAL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ FAX: _____

SPECIFIC INFORMATION TO BE RELEASED OR OBTAINED:

☐ ALL NECESSARY INFORMATION REGARDING TREATMENT ☐ BILLING/FINANCIAL
☐ OTHER: (SPECIFY INFORMATION AND PURPOSE)

_____
_____
_____

For dates of service starting: _____ to _____

RELEASE FORMAT (Please check one or both): ☐ VERBAL ☐ WRITTEN

This authorization can be revoked at any time by providing written notice to The Gentle Shepherd Counseling Center and expires *one year* from date signed. I understand that any information released prior to this revocation cannot be retrieved and The Gentle Shepherd Counseling Center will not be held responsible for such. I hereby release responsibilities that may arise from this act.

The release of information is limited to the person or agency designated above and this information is not to be disclosed to anyone else or to be used for any purpose other than what is specified.

_____ _____ _____
Client signature Or Legal Guardian Relationship Date

_____
Witness Signature Date

_____ _____
Signature to REVOKE Date Witness or Revocation Date

Any records obtained with this release
are protected under 42CFR, Part 2.

REVISED 7/2020