CHAPLAIN FAMILY LIFE MINISTRIES

AUTHORIZATION FOR RELEASE OF PRIVILEGED INFORMATION

I, _____ (_____)
(YOUR PRINTED NAME) (BIRTHDATE)

authorize _____
(CHAPLAIN'S NAME)

to release confidential counseling information related only to any suicidal ideations, gestures, and/or attempts to:

_____
(NAME OR AGENCY)

_____
(ADDRESS, CITY, STATE, ZIP)

C:_____W:_____H:_____
(CELL PHONE, WORK PHONE,AND HOME PHONE)

The specific information being requested consists of:

	Initial:	
(_) Dates of Treatment	YES_____	NO_____
(_) Treatment Plan	YES_____	NO_____
(_) Treatment Progress	YES_____	NO_____
(_) Termination Summary	YES_____	NO_____
(X) Summary of my case over the phone for purposes of continued care and help	YES_____	NO_____
(_) Number of sessions/problem summary for the purpose administrative action	YES_____	NO_____
(_) Other: _____ _____ _____	YES_____	NO_____

The requested information is needed for the purpose of: **Maintaining the client's safety during the course of pastoral psychotherapy.**

The client may revoke this authorization at any time. The revoking of this authorization shall not cancel any prior action that has already transpired. Specification of date, event, or condition upon which this consent expires is: _____. (If left blank, this consent expires after 90 days from the date of termination).

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the Family Life Ministries, its directors, chaplains and interns, and employees of the same from any and all liability that may arise from this action whether or not foreseen at present. I understand that certain records may be protected by Federal Regulations.

_____ _____ _____ _____
(Signature of Client) (Date) (Witness Signature) (Date)

_____ _____ _____ _____
(Signature of Parent/Guardian for client under 18) (Date) (Witness Signature) (Date)