PARAKALEIN COUNSELING AND CONSULTATION SERVICES, INC.

251 New Karner Road, Albany, New York 12205 Fax/Ph 518-452-9919
2 Swamp Road, West Stockbridge, MA 01266 Fax/Ph 413-232-6144

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I _________________________________, do hereby consent to and authorize Dr. Donald L. Paine, D.Min./L.I.C.S.W. to obtain from/release to:

________________________________ ________________________________
(Name of person/facility) (Address)

information pertaining to my identity, diagnosis, prognosis, and/or treatment plan.

This information is needed for the following purposes:

____ To provide ongoing assessment and treatment plan.

____ To obtain insurance, employment or government benefits.

____ To enable judges, attorneys, probation/parole officers, or health personnel to support treatment goals or make legal decisions on my behalf.

____ To coordinate treatment with my pastor/religious community.

____ To coordinate treatment with my family/concerned persons.

____ To coordinate between therapists in the agency for the treatment of the client.

____ For educational or supervisory review within that confidential framework.

____ Other:____

I understand that by law, I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose specified above. This authorization will have a duration of consent no longer than one year. I understand that I may revoke it at any to me except to the extent that action has been taken in reliance on my consent.

I understand that I am entitled to a copy of this document in its completed form.

____ ____________________
(Signature of Patient) (Date)

____ ____________________
(Signature of Witness) (Date)