Helping Hands Counseling Center, INC.

770 W. Liberty St.
Sumter, SC 29150
(v) 803-773-2088 (f) 803-773-7775
e-mail: jagshhcc@gmail.com

I hereby authorize Helping Hands Counseling Center, to obtain and release verbal or written information regarding myself, or my child, (name)_____
Date of birth, _____, which may be of help in planning my, or my child's, mental health and/or social needs.

Agency and/or individual to be contacted:

_____
_____
_____

I understand the requested information will include only data which is of the nature, and to the extent, specified below. Data will be utilized for the purpose of:

( ) Reason for referral

( ) Psychiatric Assessment

( ) Academic & Discipline Reports

( ) Positions Medication Assessment

( ) Diagnosis

( ) Current/Past Medication History

( ) Verbal and/or Written Contact

( ) History of Psychotropic Drug Use

( ) Psychological

( ) IP or OP Medical Records

( ) Individual Educational Plan

( ) Medical Assessment

( ) Psychosocial Assessment

( ) Other_____

I understand the obtained information, via telephone, facsimile or mail carrier will be held in strict professional confidence by Helping Hands Counseling, INC. I also understand I can withdraw, in writing, the use of this release at any time. This action will exclude those agencies or persons which were initiated prior to withdrawal date.

Signature:_____ Date:_____
Mailing Address:_____
Telephone: (V) _____ (C)_____

I am the (check one) Parent ( ) Legal Guardian ( ) Surrogate Parent ( )