CHRISTIAN COUNSELING CENTERS OF INDIANA

207 N. Jackson St., Auburn, In. 46706 & 1213 St. Mary's Ave., Ft. Wayne, In. 46808

Permission for Release of Information

Client's Name: _____

Address: _____

_____

City: _____ State: _____ Zip _____

Phone: (____) _____

I agree to allow the release and exchange of information about me including written reports, progress notes, and telephone calls, between my therapist at Christian Counseling Centers of Indiana and the person or agency listed below. Please consider this information confidential and share it with only those individuals designated below.

I realize and accept the responsibility for the release of this information and its potential to harm or hinder my treatment or myself in someway. I understand that this agreement will be in effect until a period of 90 days following the end of my services with Christian Counseling Centers of Indiana. I also understand that this agreement may be ended at any time by my written notice.

I have requested CCCOI obtain the following information for purposes described below:

Please Circle Your Therapist's Name:

Dr. Dan Boen, Ph.D, HSPP Dianne Stitzer, M.S., LMFT

Name _____ (Outside Agency or Doctor's Name)

Address: _____

_____

I, _____ (Client's signature or parent or guardian if client is under 18) have reviewed the above information and give my consent for its release. Dated by client this date of _____

I, _____ (signature of witness) have witnessed the above signed by the client and am acknowledging witness on their behalf. Dated by witness this date of _____