Milledgeville Christian Counseling Center

RELEASE OF INFORMATION

Name_____

Address_____Phone_____

Time Limit for Release: ☐90 days from today's date
☐One year from today's date

I authorize: Milledgeville Christian Counseling Center
366 Log Cabin Rd.
Milledgeville, GA 31061

__x__To Release to _____
Name
_____
Address

____To Release from the above Agency or Individual

THE FOLLOWING INFORMATION:			
	SOCIAL HISTORY		CORRESPONDENCE
	PSYCHOLOGICAL EVALUATION		Other:
	RECORD FROM THERAPIST		
	PSYCHIATRIC HOSPITALIZATION RECORD		
	DISCHARGE SUMMARY		
	PSYCHIATRIC EVALUATION		
	TREATMENT PLANS		
THE PURPOSE OR NEED FOR THE RELEASE OF INFORMATION			

_____ _____
Signature of Client Signature of MCC Representative and title

Date_____