Churchill Counseling Services

Release of Information to a Family Member or Significant Other

I, _____, hereby authorize the office of Churchill Counseling Services to release the following information either over the phone or in person to any of the following persons:

____ Prescription Information, Actual Prescription
____ Sample Medications (given by Physician)
____ Scheduling/Appointments
____ Other (please specify)_____

This authorization will remain in effect until termination of services from Churchill Counseling Services unless another expiration date or event is indicated here:
_____

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

I understand that I must inform Churchill Counseling Services immediately if I wish to revoke permission for any of the above individuals from receiving information from Churchill Counseling.

_____	_____
Client Signature	Date
_____	_____
Parent/Guardian	Date
_____	_____
Witness	Date