xplor counseling
377 Keahole St. E211-d, Honolulu, HI 96825 (808)343-0093

CONSENT TO RELEASE MEDICAL RECORDS

I, _____, birthdate____/____/____,

hereby authorize _____ with Xplor Counseling to have bilateral exchange of information that is contained in my medical record with:

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under the conditions listed below:

- This information will be limited to:

  ____ Psychotherapy progress notes.
  ____ Psychotherapist evaluation
  ____Other:

- Purpose or need for such disclosure: _____ Continuing care/ Treatment,and/or

_____.

- This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon _____.
  (Specific Date, Event or Condition)

- An additional consent must be obtained for any other transfer or disclosure this information.

- I understand that I may receive a copy of this release.

_____	_____
Patient's Signature	Date
_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Psychotherapist	Date