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www.accesscm.org

I give my permission for Access Counseling Group to obtain/release (circle one or both) information regarding:

Name of Client: _____ **Today's Date** _____

Date of Birth: _____

To/From (circle one or both)

Name/Agency: _____

Name/ Agency Phone Number: _____

Name/Agency Address: _____

Information to be released and/or obtained pertains to:

The purpose or need for this information is:

I understand that the information to be released and/or obtained and the need for the reason for this exchange of information. I understand that there are statutes and regulations protecting the confidentiality of authorized information. This consent is voluntary and is valid until _____ date (not to exceed one year). I also understand that I may withdraw this consent at any time except to the extent that the information has already been obtained or released.

Client or Guardian

Counselor

Date