

Daniel G. Oakes M.Ed. L.P.C.

Mental Health and Counseling Service

Release of Information Form

I understand that a professional counselor has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow a professional counselor to release some of my personal information to certain individuals or agencies.

I, _____, authorize Daniel G. Oakes Med LPC to share the following specific information with:
name

Who I want to have my information:

Name:

Contact Information:

I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What info about me will be shared:

The information may be shared: in person by phone by fax by mail by e-mail

Describe what information you are releasing:

I understand:

That I do not have to sign a release form. I do not have to allow Daniel G. Oakes M.Ed. LPC to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above.

That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Daniel G. Oakes M.Ed. LPC

That Daniel G. Oakes M.Ed. LPC and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signed: _____ Date: _____

Witness: _____