

## Consent for Release of Information

Name of Client \_\_\_\_\_

Date of Birth \_\_\_\_\_

Chinwe Williams, PhD, and **Meaningful Solutions Counseling & Consulting** is hereby authorized to release to and receive from:

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Name of Person or Entity

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Phone number & Address

### The following Protected Health Information:

**Symptoms, Treatment Plan, Diagnoses, Interventions, Response to Interventions, Treatment summary, Release Summary, Psychosocial History, Medications, Dates of Treatment or \_\_\_\_\_.**

### This Information is requested for the purpose of

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I hereby release Chinwe Williams, PhD, and Meaningful Solutions Counseling & Consulting from any and all liabilities, responsibilities, damages, and claims which might arise from the release or receipt of information authorized above. I waive any clinician/patient and or psychiatrist/patient privilege with respect to records released or received as authorized above. I understand that I can withdraw this consent at any time except to the extent that action has already been taken in reliance on it. **If not previously revoked, this consent will terminate 90 days after discontinuation of services with Chinwe Williams, PhD, and Meaningful Solutions Counseling & Consulting or upon the following date or event:**

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Signature of Client & Date

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Signature of Parent or Guardian of minor child & Date

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Signature of Clinician or Witness

### Notice to Receiving Agency or Individual

Disclosure of receipt of the information authorized above does not remove any privilege or right to confidentiality with respect to the information and does not authorize re-disclosure of the information.