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Release of Confidential Information

Re: _____(*ClientName*)_____(*Date of Birth*)

I hereby authorize and request that you release or receive information to/ from the following party (via records or phone session):
Name:_____
Address:_____
Phone:_____ E-Mail:_____Fax:_____

All medical/ psychological information and records in your possession which pertain to my treatment. The medical/ psychological information and records covered by this release include, but are not limited to, information and records regarding neurological testing, psychological testing, case notes, verbal consultation, attendance records, etc. The reason or purpose of this release is to facilitate the provision and effectiveness of counseling services. A photocopy of this authorization shall be considered as effective as the original.
I authorize this release of information:
( ) one a one time basis
( ) as long as counseling services are rendered

Client Name (Print) _____
Date of Request _____
Client Signature _____
Signature of Parent/ Guardian _____