



AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Client Name _____ Birthdate _____

Address _____ Phone _____

I authorize the exchange of information

From: _____

To: _____

Initial here for mutual exchange _____

For the purpose of _____

This release is limited to:

_____ 1) Permission to talk in detail with the requesting person or agency

_____ 2) Written summary of counseling

_____ 3) Confirmation of counseling and dates counseling was received

_____ 4) Other _____

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT, AND THAT IN ANY EVENT THIS AUTHORIZATION EXPIRES ONE YEAR AFTER THE LAST DATED SIGNATURE.

Client Signature _____ Date _____

Witness Signature _____ Date _____

360 Day Update Signature _____ Date _____