RELEASE OF INFORMATION

Client Name_____ Phone_____

Client Address_____

City_____State_____ Zip Code_____ Age_____

I AUTHORIZE: _____
TO OBTAIN FROM/OR FURNISH TO:

Attn: _____

Agency Name: _____

Phone Number: _____

INFORMATION CONTAINED IN MY MEDICAL RECORDS, FOR THE FOLLOWING PURPOSES:

- ❑ Consultation information and forms.
- ❑ Psychological Testing.
- ❑ Other:_____

This authorization is valid until a request for it to be revoked is received in writing. I understand that this information may not be released to any other organization without my permission. I release the source of these records from any liability arising from their release. A photocopy of this authorization shall be considered valid.

Client Signature_____ Date_____

Client Signature_____ Date_____

Parent/Guardian_____ Date_____