Changes Counseling, LLC
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Authorization to Release Information

Part A: I hereby authorize Changes Counseling, LLC to release information regarding:
____
(Client) (dob)
To:____
(Person, Agency) (Phone) (Fax)
____
(Street) (City) (State) (Zip)

Part B: I hereby authorize ____
(Person, Agency) (Phone) (Fax)
____
(Street) (City) (State) (Zip)
To exchange information regarding:____
(Client) (dob)
with Changes Counseling, LLC.

The purpose of such disclosure: ____
The nature of information to be disclosed:
___ assessment/diagnosis ___ treatment plan ___clinical notes ___ dates of service
___recommendations ___ summary ___ medical information ___ other_________

The information may be communicated through the following ways: Written _____Verbal ____

NOTICE OF RIGHTS:

This permission may be revoked at any time by the Undersigned. The Undersigned has the right to inspect and copy the information disclosed. Refusal to sign this form shall not result in a penalty to the person refusing to sign.

Print Name______________________________ Signature __________________________________
Date of Birth ____________________If client is under 18, a parent/guardian signature is required.
Parent/Guardian Signature____
Witness Signature __________________________________Date ____________________________
If signing for someone else, please indicate relationship: _____________________________
NOTE: This release will expire one year after its signing, unless an earlier expiration date is indicated____________

<u>Revocation of Permission</u>

Permission revoked on _______________ Signature _____________________________________
(Date)
Print Name ________________________ Witness Signature ______________________________

Life is full of changes. Make your next change a good one.
ChangesCounselingLLC.com