

# AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

If you want your counselor to speak with another professional or anyone else about yourself or any of your family members, please complete this form. Complete a separate form for each family member and for each professional or organization to whom you authorize the release of information in your client file at Secure Counseling Clinic. If you would like another agency or organization to speak with Secure Counseling Clinic about your needs, you must complete a Release of Information for that agency or organization.

In accord with my legal right to confidentiality and privileged communication relevant to services I have received, I authorize and request:

\_\_\_ The disclosure of confidential information from Secure Counseling Clinic, LLC

AND/OR

\_\_\_ Confidential information to be released by the following individual/agency to Secure Counseling Clinic, LLC.

Professional/Agency/Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Full Name of Family Member: \_\_\_\_\_

Level of Disclosure (Please choose ONE):

\_\_\_ Summary report of services received (minimum disclosure)

\_\_\_ Consultation and/or verbal communication between the above named parties

\_\_\_ Any and all records pertaining to services received

\_\_\_ Other/Specific \_\_\_\_\_

I understand that this transfer of information is for the purpose of benefitting me or my family in our services at Secure Counseling Clinic.

This release of information will be in effect for the duration of my current services at Secure Counseling Clinic with my counselor or will expire one year from the date signed below, whichever occurs first. I may revoke this release at any time by requesting and completing a Release Revocation Form.

Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

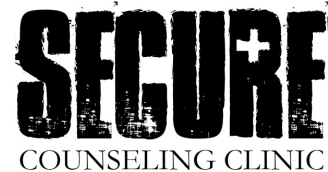
Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Our Contact Information:**

Secure Counseling Clinic, LLC  
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www.securecounselingclinic.com

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**Instructions to Client:** Both your clinician and the outside party you are requesting contact for must have a physical copy of this authorization form before any communication may be made. Please return the original hardcopy to your clinician at Secure, and provide a copy to the other party. It is also wise to retain a copy for your own records.