



Release of Information

_____ authorizes the release of information between
Client Name/Legal Guardian

Therapist
4301 Canal Ave., Grandville, MI 49418
(616)222-0631

AND

Name of Person/Organization

Street Address

City, State, Zip

Phone

Fax Number

to exchange information between themselves contained in the personal records of:

Client Name

Date of Birth

The specific information to be disclosed: _____

The type of disclosure (check all that apply):

- Verbal Exchange of Information Written Exchange of Information Faxed Exchange of Information

I am aware that I may revoke this authorization at any time by notifying in writing the person(s) authorized above.

Client Signature _____
Date _____
Therapist _____
Date

.....

I hereby REVOKE my authorization of releasing confidential information between the parties listed above.

Client Signature _____
Date