Release of Information

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

_____
Therapist

(616) 222-0631
www.alliancecounselinggroup.com

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