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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Client: ______________________________________ **Date:** ________________

I hereby authorize Choices for Change Counseling to RELEASE CONFIDENTIAL INFORMATION to and/or RECEIVE confidential information from:

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The purpose of this disclosure/request is: ____

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Information to be Released or Requested:

_____ Medical Records/Medication
_____ Custodial Evaluation
_____ Parenting
_____ Probation
_____ Case Consultation
_____ School Grades, Attendance, Behavior
_____ Other (specify) ____

_____ Counseling Records
_____ Psychological Testing
_____ Behavior Concerns
_____ Progress in Treatment
_____ Therapy Summary

This Release of Information will remain in effect for a period of one (1) year or until the specified date of ______________________________**, if less than one year.**

__________________________________ **Date:** __________________________
Client Signature

__________________________________ **Date:** __________________________
Parent or Guardian Signature

__________________________________ **Date:** __________________________
Witness Signature