Authorization for the Release of Confidential Information
Please print all information.

Client Name:_______________________________________ Client DOB:___________

Who do you want to receive the information?

Release To:____

Mailing Address:____

Phone:_________________________________ Fax:___________________________

What information do you want to be obtained/released/exchanged?

____Diagnosis/Treatment Goals
____Progress Notes / Reports / Assessments
____Court Order
____Other: ____

What do you want this information to be used for?

____Acknowledge referral / Attendance
____Legal Purposes
____Insurance/ Billing / Payment
____Other: ____

I hereby authorize Garrett Counseling and the above listed to obtain/exchange/release information concerning myself and/or family members involved in treatment. This release will be effective until _____________ or **1 year from date signed**, unless specifically requested that no further information be exchanged and the release will is terminated.

____
Signature of Guardian (if client is under 18 years) Date

____
Signature of Client (14 years and older MUST sign) Date

____
Signature of Witness Date