Authorization for Release/Exchange of Information This form provides your therapist with written permission to communicate with other individual providers regarding your treatment (e.g. previous treating therapist, current health care providers, parents or school)

Client Name(s): _____
Client Date of Birth: _____

Release of information to KLM Counseling I authorize my Therapist to release/exchange the following information:

Name: _____
Number: _____
Address: _____
Information to be released: (Please Check) _____ Screening Information _____ Behavioral and Psychological Reports _____ Treatment Plan _____ Counseling Notes _____ Coordination of Care _____ Intake and History _____
Other: _____
This release with be valid until the termination of treatment or authorization from the client to revoke
Expiration date: _____
This authorization may be revoked at any time.

Name of Patient, Client, or Authorized person (print):

_____

Signature of Patient, Client or Authorized person:

_____ Date: _____

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