Authorization for the Release/Exchange of Information

Name of Client(s): _____

(or Name of Parent/Guardian if client is under 16 years of age):

_____

Date(s) of Birth: _____

Person/Agency to release/exchange information to: _____

_____

Contact Number/Email: _____

My signature below indicates my permission for _____, a Laurel Fay and Associates therapist to release and/or exchange information with the above named party, for the purposes of treatment coordination. I understand that I have the right to rescind this permission at any time for any reason.

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Signature of Client/Parent/Guardian Date

Revised 3/2017