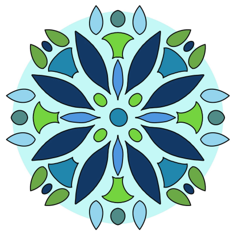

Release of Information

Name: ____

I authorize a release and exchange of information between

Name: ____

Address: ____

Phone: ____

Email: ____

for the purposes of treatment coordination and evaluation. My signature confirms that I have had the opportunity to ask questions about this release and exchange of information, and that my questions have been answered to my satisfaction. I realize that I have the right to rescind my permission at any time.

Printed Name of Client(s): ______________________________

Printed Name of Client(s): ______________________________

Printed Name of Client(s): ______________________________

Signature ____

Signature ____

Signature ____

Today's Date: ______________________________

Revised 10/4/2022