INNER CALM COUNSELING

Authorization for Release of Information

CLIENT INFORMATION

Name ____

Date of Birth ______________________ Phone ______________________

Email ____

AUTHORIZED PERSON / ORGANIZATION

Name / Organization ____

Phone _____________________ Email/Fax _____________________

Purpose of Disclosure ____

INFORMATION TO BE RELEASED

■ Assessment / Evaluation
■ Diagnosis
■ Treatment Summary
■ Treatment Plan
■ Attendance Records
■ Coordination of Care
■ Other ____

CLIENT CONSENT

I authorize Inner Calm Counseling to disclose and/or obtain the information identified above. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon it. Information released pursuant to this authorization may no longer be protected by federal privacy laws. Unless otherwise specified, this authorization expires one year from the date signed.

Client Signature ____ Date _____________

Parent/Guardian ____ Date _____________

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In-Person & Virtual Sessions Available in Colorado & New Jersey