Authorization for Release/Exchange of Information

This form provides my therapist with written permission to communicate with other individual providers regarding my treatment (e.g. previous treating therapist, current health care providers, parents or school)

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

Release of information from Alice Treves, LCSW to Another Person or Party Listed Below. I authorize my Therapist to release/exchange the following information to:

- Name: _____
- Phone Number: _____
- Address:_____

Information to be released: (Please Check) All/Any of the Below_____

Screening Information _____ Behavioral and Psychological Reports _____ Treatment Plan _____

Counseling Notes _____ Coordination of Care _____ Intake and History _____ Other: _____

This release will be valid until the termination of treatment or authorization from client to revoke or the following 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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