Oak Creek Relational Counseling Center

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____(Client's Name), , hereby grant, and authorize_____(Therapist's name and function)_____(Third Party's Name and function) authorization to share information regarding my treatment. The purpose of this release is:

_____

_____

_____

This authorization allows disclosure of information needed for the above-mentioned purpose only. It shall be valid for a period of _____months or one year from the date of signing.

Date: _____

Client's Signature _____

You have a right to request and receive a copy of this Authorization for Release of Information.

Date: _____

Therapist's Signature_____

Therapist's name and license_____