Oak Creek Relational Counseling Center

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby grant _____(Therapist) and _____permission 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.

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 Name, License or Associate # (include Supervisor Name License #)

_____

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