Still Waters Counseling

Authorization for Release of Information

I give permission to Still Waters Counseling and _____
of that agency to release / receive information regarding

_____
Name of Client — Date of Birth

to/from _____
Name of Agency and/or Individual

_____
Address — Contact Information (e.g. phone, fax, e-mail)

Information to be Released / Exchanged

Assessments
- ☐ Initial
- ☐ Psychological
- ☐ Psychiatric
- ☐ Alcohol / Substance Abuse
- ☐ Other:

Summaries
- ☐ Quarterly
- ☐ Annual
- ☐ Discharge
- ☐ Summary of Treatment
- ☐ Other:

Other
- ☐ Identifying Information
- ☐ Medications / Medical / Physical
- ☐ Treatment Concerns / Recommendations
- ☐ Progress Report
- ☐ Alcohol / Substance Abuse Treatments
- ☐ Other:

Purpose of Release / Exchange (information may only be released for the purpose(s) marked below)

- ☐ Coordination of Treatment / Service Planning
- ☐ Psychological Assessment
- ☐ Other:
- ☐ Determination of Eligibility for Benefits
- ☐ Child Custody Evaluation

This release will be valid for one year from signature date, or until the purpose of the release has been fulfilled, whichever comes first. It may be revoked by the signatory in writing at any time within this time frame.

_____ _____
Client Signature — Date

_____ _____
Parent / Legal Guardian Signature — Date

☐ I do not wish to give permission for Still Waters to communicate with the above person or agency.

_____ _____
Client/Parent/Guardian Signature — Date