Healey Ikerd, LPC, LMFT, CCMHC
HopeLife Counseling
PO Box 11051
Fayetteville, AR 72703
(479) 202-4206

RELEASE OF INFORMATION

I, _____, hereby authorize Healey Ikerd/HopeLife Counseling to release information pertaining to my evaluation and/or counseling sessions to:

_____

_____

for the purpose of: _____
(indicate the specific reason)

_____

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for one year thereafter ending on: _____

I have been informed that I may revoke this authorization by written or oral communication Healey Ikerd/HopeLife Counseling. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____
Signature of Client Date of Authorization

_____ _____
Signature of Witness Date