XarisCounseling
Transforming mind, heart, life

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AUTHORIZATION FOR RELEASE OF INFORMATION

_____
Name of Client

_____
Date of Birth

_____
Social Security Number

I understand that Pennsylvania law requires each client's consent for the release of confidential information related to mental health or developmental disability. With this understanding, I hereby waive any right to confidentiality arising under Pennsylvania law and authorize the release of records of information, but only the extent specified below.

I authorize XarisCounseling, LLC to release and/or receive the following information concerning myself or my child:

_____ Diagnostic Evaluation Results

_____ Educational Records

_____ Progress Notes

_____ Treatment Plan

_____ Treatment Summary

_____ Discharge Reports

_____ Any and All Records

_____ Other _____

The above information is only to be released to, and/or from, the following party:

_____
Name and/or Agency

_____
Address, City, State, Zip Code

This information is to be used for the purpose of _____.

This authorization shall remain in effect until _____ at which time it shall expire, and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

I hereby release the parties named above from any liabilities for release of this information.

_____
Signature of Client

_____
Date

_____
Signature of Witness

_____
Date