EXCHANGE / RELEASE OF INFORMATION

CLIENT INFORMATION

Client's Name: ____

Date of Birth or Social Security #: ____

Address: ____

I AUTHORIZE MASTERPEACE COUNSELING TO EXCHANGE/ RELEASE THE FOLLOWING:

_____ Acknowledgement of counseling or testing services

_____ Assessment information

_____ Treatment concerns or recommendations

_____ Progress report(s)

_____ Other ____

THE INDIVIDUAL / PROFESSIONAL / BUSINESS I WISH MASTERPEACE COUNSELING TO EXCHANGE / RELEASE INFORMATION WITH:

Name/Business: ____

Address: ____

Phone Number: ____

This release will be valid until ____________________ or for one (1) year from the signature date. It may be revoked by the client or the guardian in writing anytime within this time frame. Persons or agencies receiving information may not further release the information without the informed, written consent of the client. The Organization offers a copy of the signed form to the party authorizing the disclosure of information when requested.

Client's Signature: ____ Date: _____________________

Parent/Legal Guardian's Signature: _____________________________ Date: _____________________

MASTERPEACE Staff exchanging or releasing information:

Signature: ____ Date: _____________________