CLS Counseling
Clarity, Learning, Support

RELEASE OF INFORMATION
CONSENT FORM

The placement of my initials indicates my consent to the disclosure of this information as outlined by the following parameters. This consent is in effect until revoked in writing.

I, _____ hereby authorize _____ of CLS Counseling, to:
(Client-Print Name) (CLS Counseling Therapist)

Initial _____ Discuss (verbally or in writing) any relevant information that has been brought up during treatment with the person/s or staff of clinic, office, agency, or institution/s listed below.

Initial _____ Obtain any relevant information contained in my records from the person/s or staff of clinic, office, agency or institution/s listed below.

Initial _____ Provide any relevant information contained in my records to the person/s or staff of clinic, office, agency or institution/s listed below.

List the name(s) of the Counselor, Teacher, Clinician, Clinic, Office, Agency or Institution:

1. Name_____ Phone:_____

2. Name_____ Phone:_____

3. Name_____ Phone:_____

4. Name_____ Phone:_____

Confirm your consent for release of information or records:
□ **Educational/Transcripts/Assessments** □ **Psychological** □ **Medical**

Please state if there are any specific exclusions to the Education, Psychological or Medical record disclosures:

_____

_____

Client/Guardian Signature: _____ Date: _____

Client/Guardian Signature: _____ Date: _____

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