My Holistic Self Counselling

Heal. Grow. Expand.

Authorization to Release Confidential Information

I, _____ Date_____

(Name of Client)

Authorize the ☐ verbal and/or ☐ written release and exchange of my confidential medical, psychological, psychiatric, vocational. And/or other information as appropriate between the following specific individuals/organizations:

☐From ☐To My Holistic Self Counselling: Jennifer Jurkofsky
☐From ☐To Spouse/Partner/Family Member: _____
☐From ☐To Health Care Professional: _____
☐From ☐To Lawyer: _____
☐From ☐To Insurance Company: _____
☐From ☐To Employer: _____
☐From ☐To Other: _____

Subject to the following exclusions and limitations:

_____
_____
_____
_____

I understand that I may revoke this consent at any time by informing the above parties in writing.

_____ _____
(Client Signature) (Date)

_____ _____
(Parent/Guardian Signature it Required) (Date)

_____ _____
(Witness Signature) (Date)

This release of information remains in effect for one year from the date of signature unless otherwise notified