CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Lynne Harris, LPC, LCSW
200 N. 9th Street, Suite A.
Columbia, Missouri 65203

( ) to release information to
( ) to receive information from

Name: _____

Phone:_____ email address_____

Regarding _____ Date of Birth_____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:

_____

_____

Nature and extent of information to be disclosed:

_____

_____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to Lynne Harris at the address above. I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

_____ _____
Signature of Client, Parent, Guardian Date

_____ _____
Signature of Witness Date