CORE BALANCE
COUNSELING

Authorization for Release and Exchange of Information

I,_____,_____,_____
client name date of birth social security number

authorize Core Balance Counseling, LLC, to exchange the information checked below with the below mentioned party:

_____
(Name of party) (Phone #) (Fax # / Email)

_____ Mental Health Info. _____Substance Abuse Info. _____Medical Info.

_____ Other (describe) _____

_____ If checked, both parties may exchange information.

This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of this authorization, further release of information shall cease immediately. This consent will expire automatically upon completion / termination of treatment. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purposes of the disclosure.

_____
Client Name Printed

_____ _____
Client Signature Date

_____ _____
Signature of Parent/Guardian if applicable Date