Audrey DuRoss, LCSW

2001 Corner Creek Ln, Unit 77
Jackson, WY 83001
801-901-7193

CONSENT TO RELEASE INFORMATION

I, _____ do hereby authorize information to be released from and to Audrey DuRoss, LCSW from and to _____.

The purpose for releasing information is:

- ☐ Coordination of services
- ☐ Consultation
- ☐ Provision or reports needed by school, work, or funding agency
- ☐ Other _____

Information to be released included:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Treatment description
- ☐ Recommendations
- ☐ Anything that Audrey DuRoss' discretion deems relevant and / or important

This release shall remain valid until _____, I understand that i may revoke this release at any time by providing the above party with written instruction to do so.

_____ _____

Client's Name **Date**

_____ _____

Client's Parents Name
(if client is a minor) **Date**

_____ _____

Provider Name **Date**