Audrey DuRoss, LCSW

3070 Rasmussen Road Suit #121 Park City, UT 84098 801-910-7193

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
- ☐ Other _____

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.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent of Guardian Date

(if client is a minor)

_____ _____

Witness Date