FonthillCounseling

Authorization to Release Information

CLIENT	DOB
GUARDIAN	

I, _____, have been informed of, and understand my rights concerning the release of confidential information. I give permission for staff of Fonthill Counseling to release/exchange/receive information including the following:

□ Client Information
□ Evaluation Results
□ Psychiatric Diagnosis
□ Treatment information
□ Other:_____

The above information may be released or exchanged in person, by phone, fax, email or in writing between the staff at Fonthill Counseling and:

_____
_____
_____

This consent is valid for one year from the date of signing unless indicating an earlier expiration date here: _____.

I understand that I may revoke this consent at any time. However, notification of the revocations of this release will be provided to Fonthill Counseling in writing only. I have a right to inspect and review the information that will be released under the supervision of my therapist/clinician.

_____

Client/Guardian Signature Date