CAMBRON COUNSELING

Authorization for Release of Information

Today's Date: _____

Patient's Name: _____

Date of Birth: _____

By signing this release, consent is given for the exchange of otherwise confidential information between Cambron Counseling, and the individuals/agencies named below. This authorization includes all information available in my clinical record, unless specifically listed in exclusions.

Information Exchange Authorized with:

_____

_____

_____

_____

Limitations or Exclusions of Information to be disclosed: (please specify)

_____

_____

The authorization expires one year from this day, unless otherwise noted, and I have the right to revoke this authorization at any time.

Signature of client or Parent/Guardian _____

Print Name (s) _____

Date_____

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