

Clarity Counseling, LLC

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Authorization to Release Confidential Records and Information

Client Name _____ DOB _____

This will authorize Clarity Counseling to release information to and receive information from the following party:

Name _____

Address _____

Telephone _____

Fax/Email _____

The following information is authorized to be exchanged:

- Information regarding services currently being provided
- Information regarding past services
- Treatment reports/summary/assessments
- Family Involvement
- Emergency contact
- Substance Use Information
- Other: _____

I have had explained to me and fully understand this request and authorization and authorize the release of records and information as described above. I understand I may revoke this consent at any time except to the extent that information has already been released. This consent will automatically expire one year from the signed date, on _____.

Signature of Client Date

Signature of Parent/Guardian (if applicable) Date

Primary Therapist Date