River Bend Counseling

Marnee Alfson, MA, LMHC

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize the Counseling Center to:

☐release to:
☐obtain from:
☐exchange with:

_____
_____

the following information pertaining to myself:

☐ treatment summary
☐ history/intake
☐ diagnosis
☐ other (specify) _____
☐ psychological test results
☐ psychiatric evaluation/medication history
☐ dates of treatment attendance

for the purpose of:

☐ evaluation/assessment and/or coordinating treatment efforts
☐ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Signature of Client Date Social Security #

OR _____
Date of Birth

_____
Signature of Witness Date