adulteen
COUNSELING

Release of Information Form

_____ ____/____/_____
(Client name) (Date of birth)

_____
(Address)

_____ _____ _____
(City) (ST) (Zip)

I hereby authorize and request:

_____
(Therapist name)

Adulteen Counseling, LLC
215 N 2nd St, Suite 109
River Falls, WI 54022
715-629-7047 (phone)
651-925-0052 (fax)

_____ to disclose to _____ to receive from _____ to exchange with (initial one)

_____
(Name)

_____
(Agency)

_____ _____
(Address) (Phone)

_____ _____ _____ _____
(City) (ST) (Zip) (Fax)

The following specific information from my records: _____
(month/year of treatment)

___ Clinical records
___ Court records
___ Academic records
___ Billing records
___ Psychiatric evaluation results
___ Medical records
___ All of the above
___ Other: _____

The purpose of such disclosure is: _____

I understand that I have the right to inspect and receive a copy of the material to be disclosed. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning the release of information. I may revoke this authorization in writing at any time except to the extent that information already released pursuant to this consent cannot be recalled. This authorization is effective for one (1) year from the date signed or as specified by the condition stated here, if any: _____

_____ _____
(Signature of client or guardian) (Date)