Recovery Life Coaching

Thriving Beyond Addiction

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Address: _____

Information to Be Released

Description of Information: _____

Purpose of Release: _____

Recipient Information

Name/Organization: _____

Phone Number: _____

Fax/Email: _____

Authorization and Expiration

This authorization will expire on _____ or upon written revocation by the client. I understand that once information is released, it may no longer be protected under privacy laws.

Signature

Client Signature: _____ Date: _____

Witness/Representative Signature: _____ Date: _____

I understand that I have the right to refuse to sign this authorization and that my refusal will not affect my ability to receive treatment, payment, or eligibility for benefits.