CRM COUNSELING,
LIFE COACHING, AND WELLNESS

Authorization for Release of Information

I, _____ DOB: _____
(client name) *(date)*

hereby authorize, _____
(counselor name)

to release the following information in my records to:

_____
(name of counselor/doctor, etc.)

- MEDICAL HEALTH AND MEDICAL HISTORY, INCLUDING DIAGNOSIS
- RECORDS OF OUTPATIENT TREATMENT
- RECORDS OF HOSPITALIZATION AND INPATIENT TREATMENT
- ALL DIAGNOSTIC PSYCHOLOGICAL ASSESSMENTS
- OTHER, SPECIFY: _____

I understand that I have the right to revoke my consent of any future disclosure in writing at any time. I have discussed with my counselor the issues concerning my privacy and confidentiality and this consent.

This is to be a: ❒ one-time consent ❒ continuing consent.

_____ _____
Signature of Client or Guardian if a minor *Date*

_____ _____
Printed name *Relationship to client (if necessary)*

_____ _____
Signature of Counselor/Witness *Date*