Internal Strength Counseling, LLC
Kelli Silhavy, LCSW, MSW
4787 Sunset BLVD, Suite 100, O'Fallon, IL
Office Phone: 618-671-0817
Office Fax: 618-726-2035

Authorization to Release Information

Client's Name: _____
Date of Birth: _____

I hereby authorize Kelli Silhavy, along with Internal Strength Counseling, to obtain and/or release documents and information from my records to the provider listed below.

_____ obtain from the listed provider _____ release to the listed provider

Name: _____
Address: _____
Phone: _____

The records being transferred are required for the specific purpose of:
_____ coordination of care with other treatment professionals
_____ transfer of treatment
_____ family involvement in current treatment
_____ other _____

I understand that my authorization will remain effective from the date of my signature until I ask to revoke my authorization. I understand that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.
I have read and understand the nature of this release.

_____
Client Signature Date

_____
Parent Signature (12 and Under) Date

_____
Therapist or Witness Signature Date