

# Motivate Counseling

## Authorization to Release Information

CLIENT	DOB
GUARDIAN	

I, \_\_\_\_\_, have been informed of, and understand my rights concerning the release of confidential information. I give permission for staff of Motivate Counseling to release/exchange/receive information including the following:

- Client Information
- Evaluation Results
- Psychiatric Diagnosis
- Treatment information
- Other:

\_\_\_\_\_

The above information may be released or exchanged in person, by phone, fax, email or in writing between the staff at Motivate Counseling and:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This consent is valid for one year from the date of signing unless indicating an earlier expiration date here: \_\_\_\_\_. I understand that I may revoke this consent at any time. However, notification of the revocations of this release will be provided to Motivate Counseling in writing only. I have a right to inspect and review the information that will be released under the supervision of my therapist/clinician.

\_\_\_\_\_

Client/Guardian Signature

Date