



Deer Valley Counseling

"Skills for Better Living"

Authorization for Release of Confidential Information

I, _____ Date of Birth: _____
(Client's Name and/or Legal Guardian)

hereby authorize Deer Valley Counseling to release information to the following person or organization and for the following person or organization to release information to Deer Valley Counseling:

(Person/Organization) (Telephone Number)

(Address) (Fax)

I understand that the purpose of the disclosure is to -

Comply with client's request Coordinate treatment Other _____

The information to be disclosed includes -

All mental health records Other _____

Progress in treatment Attendance Participation

Diagnoses Evaluations Assignment completion

Treatment Plan Alcohol and/or drug addiction treatment

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be redisclosed by the recipient and at that time would no longer be protected by the original disclosing person or organization. I agree that a photocopy or facsimile of this authorization is as valid as an original. This authorization for release of information will expire on

One year after the date it was signed Other _____

Date Signed: _____

Printed name of Client

Signature of Client

Printed name of Witness

Signature of Witness

Printed name of Parent/Guardian

Signature of Parent/Guardian