



Deer Valley Counseling

"Skills for Better Living"

Authorization for Release of Confidential Information General

I, _____ Date of Birth of Client: _____
(Client's Name or Person Authorized to Sign for Client)

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 via telephone
- Coordinate treatment via telephone and by sending records
- Other _____
- Coordinate treatment by sending records

The information to be disclosed includes -

- All mental health records
- Alcohol and drug abuse information
- Other _____

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 originator. I understand that Deer Valley Counseling may not condition services upon my signing this authorization unless the services are provided to me for the purpose of creating health information for a third party. This authorization for release of information will expire on

_____ (if left blank, one year from the date it was signed).

Printed name of Client Signature of Client Date Signed

Person Authorized to Sign for Client Signature of Person Authorized to Sign Date Signed

Reason person may sign for client: Parent Guardian Other: _____