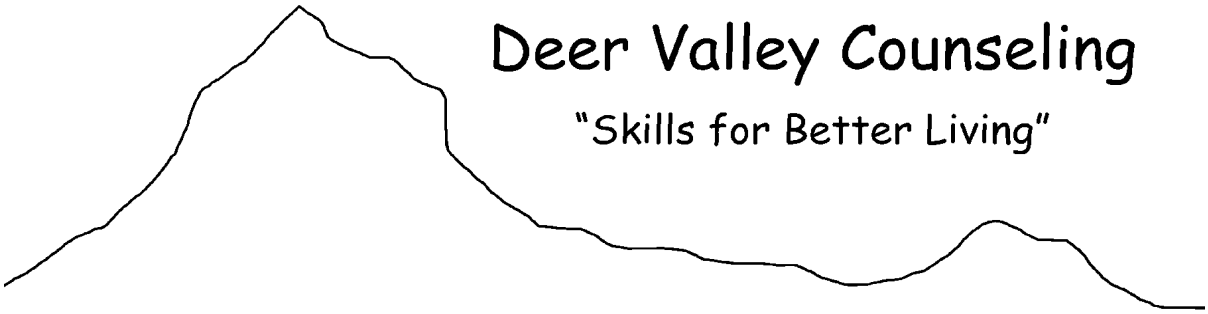

Authorization for Release of Confidential Information
General

Client Name: _____ Date of Birth: _____

I 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)

*Something **must** be checked or written in this box.*

I understand that the purpose of the disclosure is to -

☐ Comply with client's request ☐ Other _____

☐ Coordinate treatment via telephone ☐ Coordinate treatment by sending records

☐ Coordinate treatment via telephone and by sending records

*Something **must** be checked or written in this box also.*

The information to be disclosed includes –

☐ All mental health records including alcohol and drug abuse evaluation and treatment 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: _____

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