Sue E. Ouellette, LMFT

Authorization for Release/Disclosure, and/or Exchange of Information

I, _____ DOB_____

Address:_____

Authorize the release and exchange of information from my counseling record or the counseling record of a minor :

Minor's name _____ DOB_____

This information may be _____ released to and/or received from_____

Name of provider or organization_____

Address_____

Phone #_____ Fax #_____

For the following purpose, use, or need:

_____Assessment _____Medical service

_____Case Coordination _____Payment for services

_____ Attendance _____ Transportation

Other:_____

Information to be released shall include: _____All

_____Treatment progress _____)Initial assessment/evaluation

_____ Treatment summary _____ Treatment goals

_____ Discharge summary _____ Attendance dates

Other:_____-
This information may be released by:

_____Written _____ Verbal exchange _____Fax

_____Discharge summery _____ Electronic e-mail method

Date:_____

Counselor's signature:_____

Client's signature:_____

By law, this agreement will expire 90 days after discharge or on_____

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