



La Vie Counseling Associates

Consent to Release Information

CASE NAME _____

DATE OF BIRTH _____

COUNSELOR _____

This release of information form authorizes information from my records (or my child's records) to be shared between the counselor listed above and the person(s) or agency listed at the bottom of this form.

I give permission to the counselor listed above and the person(s) or agency listed below to share and exchange the following information:

_____ Educational

_____ Psychiatric

_____ Medical

_____ Social

_____ Psychological

_____ Psychometric Testing

I understand that this authorization is valid for two years from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

Person(s) / Agency

Signature of Client

Street Address

City

Zip

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Witness/Title (Counselor)