AUTHORIZATION TO RELEASE INFORMATION

Name of Client_____ Date of Birth _____

I hereby consent to allow the release and mutual exchange of information including educational, medical, social, psychiatric, chemical dependency treatment, and other relevant information between Center Street Counseling Services and:

_____
Agency Name

_____
Agency individual releasing information

_____
Street Address City/State/Zip

_____
Telephone

INFORMATION REQUESTED

__ Diagnosis
__ Treatment Summary
__ Social History
__ Psychiatric Evaluation
__ Psychological Report
__ Court Order/Reunification Plan
__ Educational Summary
__ Other_____
_____

I further release Center Street Counseling and its employees and agents from any liability arising from the release of this information or records from such designated persons or agencies. This consent will expire one year from the date of signing. This consent is subject to written revocation at any time except to the extent that action has already been taken.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date