Release of Information Authorization

This form, when completed and signed by you, authorizes me to obtain information and/or release information from your clinical record to and/or from the person/organization you designate.

Name of Client: _____ Date of birth: _____

I authorize my counselor, David Roper, MS, LPC to (please check one or both):

obtain information FROM ____ (allows me to get info from this person/organization)

provide information TO _____ (allows me to give info to this person/organization)

Name of person/organization _____

Phone (cell or work # ?) _____

Email address _____

regarding all information that's deemed necessary for this client's treatment. This authorization shall remain in effect until the following future date _____ .

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address.

_____ _____
Signature of Client (or parent/legal guardian for minors) Date

_____
Printed Name of Signature above