ARBOR COUNSELING CENTER
CONSENT FOR RELEASE OF INFORMATION

Client Name _____ Date of Birth _____

I, _____ hereby authorize Arbor Counseling Center to:

☐ RELEASE TO: ☐ RECEIVE FROM:

Name: _____

Address: _____

Phone #: _____

THE FOLLOWING INFORMATION:

☐ Case Progress
☐ Attendance
☐ Progress Notes
☐ Psychological Reports
☐ Treatment Recommendations
☐ Diagnosis and Diagnostic Impressions

AND/OR _____

FOR THE PURPOSE OF:

☐ Coordination of Services
☐ Treatment Recommendations
☐ Attendance Compliance

AND/OR _____

I understand that my authorization will remain effective from the date of my signature until _____, and the information will be handled in compliance with all confidentiality laws, and that I may revoke the authorization at any time by written, dated communication.

Client's Signature_____Date_____

Parent's Signature_____Date_____
(If client is under 18 years old)

Witness _____Date_____