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# Authorization to Release Confidential Records and Information

Client Name: ______________________________ DOB: ___________________________

Client Address: ____________________________ Phone Number: ____________________

I hereby authorize Well Life Counseling and Consulting, LLC to release to, and receive from

_____________________________________________________________________________

_____________________________________________________________________________

(Facility/Person receiving information and address/phone number)

Purpose of Disclosure: ________________________________________________________

Date of treatment/Services: _________________________________ (approximate if necessary)

___Intake/Discharge Summaries ___Medical History/Assessments ___Treatment Plans
___Psychological Reports ___Social History ___Legal Information
___Education Records ___Progress/Treatment Notes ___Diagnostic Results
___Court ordered Evaluations ___Other

NOTE: This request is entirely voluntary on my part. I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken. This consent will expire after one year from signing unless otherwise noted: ___________________________

I fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release.

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| Signature of Client | Printed Name | Date |
| Signature of Parent/Guardian | Printed Name | Date |
| Signature of Parent/Guardian | Printed Name | Date |
| Signature of Witness | Printed Name | Date |