Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individual providers regarding your treatment (e.g. previous treating therapist, current health care providers, parents or school)

Client Name(s): _____

Client Date of Birth: _____

Release of information from Trisha Cupero, LCSW (One Breath Counseling, PLLC) to Another Person or Party Listed Below.

I authorize my Therapist to release/exchange the following information to:

Name: _____

Number: _____

Email address: _____

Address: _____

Information to be released: (Please Check)
_____ Screening Information
_____ Behavioral and Psychological Reports
_____ Treatment Plan
_____ Counseling Notes
_____ Coordination of Care
_____ Intake and History
_____ Other: _____

This release with be valid until the termination of treatment or authorization from client is revoked.

Expiration date: _____

This authorization may be revoked at any time.

Name of Patient, Client, or Authorized person (print):

_____

Signature of Patient, Client, or Authorized person:

_____ Date: _____

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