Client Information

Client's Name:_____

Date of Birth:_____ Today's Date:_____

Recipient Information

I, _____, am authorizing Footprints Counseling to □ release and/or □ obtain information from the mental health records of the client indicated in the above Client Information section to/from:

Name of person / facility:_____

Address:_____

Phone Number:_____ Email:_____

I authorize information to be shared by □ mail □ phone □ email. The following information may be released or obtained:

□ Entire Record □ Medical / Medication Information □ Treatment Plan

□ Mental Health Assessment □ School Information □ Progress Updates

□ Other: _____

Authorization and Signature

I authorize the release of the confidential protected health information, as described in my directions above. I understand that this authorization is voluntary and that I can revoke it at any time by notifying Footprints Counseling of my wishing in writing. I can also refuse to sign this release and it will not change my right to receive treatment.

Client / Guardian Signature:_____ Date:_____

Counselor Signature:_____ Date:_____