4119 Whipple Ave. NW,
Suite B
Canton, Ohio 44718
Phone: 330-703-6578
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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Clients Full Name: _____

D.O.B._____

_____ release to: _____

_____ obtain from: _____

_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself and or client :

_____ treatment summary

_____ history/intake

_____ diagnosis

_____ psychological test results

_____ psychiatric evaluation/medication history

_____ dates of treatment attendance

_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts

_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, _____.I also understand that I have the right to increase or decrease the amount of time this authorization is in effect.

Check One:

_____ 6 months

OR

_____ Other Date

_____
Signature of Client

_____
Print Name of Client

_____
Date

_____
Signature of Parent/Guardian

_____
Print Name of Parent/Guardian

_____
Date

_____
Signature of Therapist

Notice: to any agency receiving any information due to this release, you are receiving information that according to federal law (reg.42 CFR, Part 2) and may not be further disclosed except as authorized by a court order (i.e. incidents of suspected child abuse andneglect). The general release of information is not significant for this purpose. The information disclosed by this release is done sofrom records protected by federal law. Violation of federal law is a crime and may be reported to the US district attorney.