Collaborative Marriage & Family Counseling
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Client's Authorization for Exchange of Information

Client Name(s)_____DOB:_____

Address_____

City_____State_____ Zip Code_____

Organization or person with whom information will be exchanged (check one or both):

Information will be REQUESTED from the person/agency. ☐

Information will be RELEASED to the person/agency. ☐

Agency or Person_____ Phone_____

Address_____ City_____Zip_____

Agency or Person_____ Phone_____

Address_____ City_____Zip_____

Agency or Person_____ Phone_____

Address_____ City_____Zip_____

Description or list of information to be exchanged:

I consent to the release of the above described information. I can inspect and copy the written information that is being exchanged, and I have the right to be told what was exchanged in verbal communication. In any case, the information will not be re-released to anyone without written authorization. I understand that this consent is valid for one year from the date of my signature below and can be revoked at any time.

Signature(s)_____Date_____

Therapist_____Date_____