A FAMILY WORKS, COUNSELING PLLC

1760 E Boston St, Suite 102
Gilbert, AZ 85295
(480) 649-6499

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Client Name: _____

I authorize A Family Works, Counseling PLLC to release to, obtain from, and exchange PHI (Protected Health Information) for the above-named client, with:

Name / Agency _____

Phone _____

Address _____

_____

The following information to be released:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ dates of treatment attendance
_____ financial records
_____ 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.

I understand I have the right to refuse to sign this form, and that I may revoke my consent, in writing, at any time (except to the extent that the information has already been released).

_____ _____
Client Name Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

_____ _____
Witness Date