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Authorization to Release/Exchange Confidential Information

I, _____ authorize Stevie Wilson, LPC to:
Client name or Guardian name and date of birth

- _____ release to:
- _____ obtain from:
- _____ exchange with:

Name and contact information regarding release of information

the following information pertaining to the client:

- _____ treatment summary
- _____ history/intake
- _____ diagnosis
- _____ psychological test results
- _____ psychiatric evaluation/medication history
- _____ dates of treatment attendance
- _____ other (specify) _____
- _____ All of the above

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, condition, or event.

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

Signature of Client

Date

Signature of Stevie Wilson, LPC

Date