AVENUES OF COUNSELING AND MEDIATION, LLC

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AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____
Client Name Date of Birth

I hereby authorize _____and Avenues of Counseling and Mediation, LLC,
Clinician Name

TO RELEASE TO:_____ or

TO REQUEST FROM:_____

PERSON/ORGANIZATION:_____

ADDRESS:_____

PHONE:_____ FAX:_____

_____Treatment Summary
_____Medication Records
_____Achievement Testing Results
_____Billing Records
_____Treatment Plan
_____Other

REASON FOR RELEASE/DISCLOSURE:
_____Coordinate Treatment
_____Gather Assessment/Treatment Planning Information
_____Other

This consent may be revoked at any time by providing written notice to Avenues of Counseling and Mediation, LLC and/or the party named above. I understand that any information released before a written notice cannot be retrieved and Avenues of Counseling and Mediation, LLC and the other party named, will not be held responsible for such. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations, Avenues of Counseling & Mediation, LLC will be held harmless.

_____ _____ _____
Signature of Client Print Name Date

_____ _____ _____
Signature of Parent/Guardian Print Name Date

_____ _____ _____
Signature of Witness Print Name Date