BILATERAL RELEASE OF CONFIDENTIAL INFORMATION

Date:_____

Counselor:_____

I hereby authorize use or disclosure of protected health information about me as described below.

I give _____ permission to disclose and/or receive disclosure of my confidential record with _____

1. The specific information that may be disclosed is any records concerning:_____

_____

_____

3. This authorization is effective immediately and expires on:_____

_____ _____

Clients Name (Please print) Client Signature Date

Copy given to: ❑ Client ❑ Other Party ❑ Parent ❑ Guardian ❑ Representative