Authorization for Release of Information

IMAGO
COUNSELING & SOUL CARE

Client Name: _____

Address: _____

_____

Phone: _____

_____ I authorize my counselor to release and/or obtain information from:
(Initial here)

Name of person and/or organization: _____

Address: _____

_____

Phone/Fax: _____

Email address: _____

I authorize information to be released by the following methods of communication:

_____ Phone _____Fax _____ Email _____ Mail
(Initial here) *(Initial here)* *(Initial here)* *(Initial here)*

The information to be released is regarding: _____

_____

I understand that:

- I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.
- I may revoke this authorization at any time by submitting a written request to my counselor.
- This authorization will expire on: _____

I certify that this form has been fully explained to me and that I understand its contents.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Counselor: _____ Date: _____