Grace Counseling Services, PLLC

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Client's Name:____

Date of Birth:__________________ Social Security Number:____________________

I hereby give permission for, Grace Counseling Services, PLLC, to

☐ Release Information to ____

☐ Obtain Information from ____

Information to be exchanged includes the following:

☐ Identifying Information	☐School Grades	☐Hospital/Medical Records
☐Session Notes	☐IEP/School Records	☐ Prescription Medication
☐ Appointment Information	☐Behavioral Interventions	☐Substance Abuse Records
☐Contact Summaries	☐Disciplinary Records	☐ Prognosis/Recommendations

☐ Other Information:____

Authorization and Signature: I authorize the release of the information indicated above. I understand this authorization is voluntary, that the information to be disclosed is protected by law and the use/disclosure is to be made per my directions. I understand that to revoke this authorization I must provide a written request and the revocation will not apply to action or information that has already been released/obtained in response to this authorization. Any information obtained as a result of this release is confidential. I understand this release will expire one year from the date it is signed.

Signature:____ Date:____________________

Witness:____ Date:_____________________