

Hope Counseling Center

Request and Authorization to Exchange Information

I, _____ Soc. Sec. No. _____
Client's Name

authorize Hope Counseling Center
926 Aspen
P.O. Box 73511
Fairbanks, AK 99707
451-8208

and _____

to release and exchange with each other **written** or **oral** (circle one or both) reports concerning the following:

- _____ diagnosis
- _____ attendance in counseling
- _____ participation in counseling
- _____ psychiatric reports/evaluations
- _____ clinical progress
- _____ verbal information
- _____ other (specify) _____

I understand that no disclosure of my records can be made without my written consent unless otherwise provided for in legal statutes and judicial decisions. I also understand that I may revoke this consent at any time except to the extent that action has already been taken upon this release.

Client's signature

Staff member

Date

Witness

Release good for 6 months following date signed.