Authorization for Release of Information

Client's Name ____ Date of Birth _____ / _____ / _____
[please print]

I authorize Stone Bridge Counseling Center, Inc. to:

☐ provide to: ☐ receive from:

Facility/Person: ____

Address ______________________________________ ________________ __________ ____________
Street City State Zip Code

Information to be provided by
Stone Bridge Counseling Center, Inc.:

☐ Individual Assessment
☐ Test Results
☐ Treatment Summary
☐ Telephone Consultation
☐ Other ____________________

Information requested by
Stone Bridge Counseling Center, Inc.:

☐ Individual Assessment
☐ Test Results
☐ Treatment Summary
☐ Telephone Consultation
☐ Other ____________________

This information is being disclosed to the above identified parties from records whose confidentiality is protected by Federal law. This authorization is effective for 12 months and may be terminated at any time, except to the extent that the program, which is to make the disclosure, has already acted in reliance upon it.

I hereby release the named parties [requesting and receiving information] from all legal liability that might arise from the release of the information requested.

I consider a photocopy of this authorization to be as valid as the original.

Client's Name ____ Date _____ / _____ / _____

Client's Name ____ Date _____ / _____ / _____

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