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AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION

I, _____, hereby authorize _____ to share the specified information in my client record with my mental health counselor Rob Womack, M.Div; LPC. Unless otherwise stated, this release is reciprocal, meaning that Rob Womack may share the below specified information with the party named above.

This information shall include (initial each applicable item):

- Psychological Evaluation _____ Psychiatric Evaluation _____
- Screening/Admission Information _____ Diagnostic Information _____
- Service Plan _____ Substance Abuse Diagnosis and Treatment _____
- Medical Information _____ School Records (conduct, academic) _____
- Summary of Treatment _____ Discharge Summary _____
- Other _____

Limitations on this release of information:

The purpose of the disclosure is to

- Assist with treatment
- Assist with a Referral
- At the Request of Client
- Other:

I have not been coerced to sign this release and I understand that my treatment is not conditional on my signing. I understand that I can revoke this authorization at any time. If not revoked earlier, this authorization expires automatically on _____ or one year from the date it is signed, whichever is earlier.

Client (or legally responsible party) Signature and date

Client's Full name and date of Birth