Horizon Hope Counseling, Inc.

A Place to Heal….The Courage to Change

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REQUEST TO RELEASE INFORMATION
ATHORIZATION FORM

I _____, do hereby authorize
(Name of Client)

_____

_____

to release to: _____

_____

_____

_____

the following information (initial as appropriate)

_____ Evaluation of my current medical health and a summary of any active medical treatments being offered, including any prescribed medications.

_____ My educational records, including results of educational diagnostic evaluations, testing, and school performance/grade records.

_____ A summary of my psychiatric/psychological evaluations. Including test results, diagnostic impressions, and treatments offered.

_____ Exchange of information regarding diagnosis treatment.

I understand that this consent will remain in effect unless revoked by me in writing.

_____ _____
Client's Signature (18 and Older) Date

_____ _____
Custodial Parent(s)/Guardian (for clients less than 18) Client's Date of Birth

_____ _____
Witness to Signatures Client's Social Security #

NOTICE TO RELEASING AGENCY/PERSON: We will not redisclose any information you send unless the consenting client specifically directs us to do so.