A.V.O.S. COUSNELING CENTER AND TRAINING INSTITUTE, LLC

Consent for Release of Confidential Information

Please fill this form and include any family members, previous therapists, your primary care physician and/or anyone else you would like me to speak with about your case. If this does not apply to you, you may leave this form blank.

Date: _____

Client Name(s): _____

Address: _____

Phone number: _____

I, _____, ( ) client, ( ) parent, ( ) guardian, hereby authorize Erica Bonham, MA, LPC, to release or exchange information concerning my psychological or medical history/treatment.

Authorization is granted to:

_____ _____

Person/Agency **Phone/Fax Number(s)**

_____

Address **City** **State** **Zip**

I authorize the release of the following information:

- _____ **Psychological or psychiatric evaluation**
- _____ **Psychodiagnostic assessment results (testing)**
- _____ **Treatment plan/summary**
- _____ **Social History**
- _____ **Medical history and information**
- _____ **As needed for treatment**
- _____ **For scheduling only**
- _____ **For Financial Purposes Only**
- _____ **Other (specify)** _____

I understand that I may withdraw this authorization in writing at any time.

_____ _____

Signature of Client/Parent/Guardian **Please Print Name**

Date: _____

A copy of this release shall be as valid as the original.

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