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 Kristen McGeehon, LPCC, 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.

A.V.O.S. Cousneling Center and Training Institute, LLC

AVOS Counseling Center and Training Institute Arvada, CO 80002
ericabonham@gmail.com 303 880 7793