



# RELEASE OF CONFIDENTIAL INFORMATION

Client's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

I hereby authorize **Peg Roberts, LMFT / Spirit of Hope Counseling Center** to exchange information regarding my counseling sessions. This could include progress notes, diagnosis, a phone consultation or discharge summary. This information is for continuity of care and/or collaboration.

You have my permission to talk to:

_____ Professional's Name / Organization	_____ Professional's Name / Organization
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone / Fax / Email	_____ Phone / Fax / Email

I understand that I may evoke this authorization, in writing, at any time and that upon fulfillment of the above stated purpose, this authorization will expire. In any case, this authorization will automatically expire one year from the date signed.

_____ Client Signature	_____ Date
_____ Client Signature	_____ Date