spirit of hope
Counseling Center

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

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