

3610 N. 44<sup>th</sup> Street, Suite #120  
Phoenix, AZ 85018  
602-218-6901

**CONSENT FOR RELEASE OF INFORMATION**

\_\_\_\_\_  
(CLIENT)

\_\_\_\_\_  
(DOB)

\_\_\_\_\_  
(SSN)

I hereby authorize \_\_\_\_\_

to exchange the following information (circle): *Assessment/Evaluation / Diagnosis/Prognosis Triage/Discharge Summary / Psychosocial History / Treatment Plan(s) / Progress Notes / Other:* \_\_\_\_\_

With the following person(s) or organization (including contact information):

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

The purpose of this exchange or disclosure of information: \_\_\_\_\_

I understand that I may revoke this release at any time, except to the extent that the practice has taken action in reliance of the consent. Such revocation must be in writing and submitted in writing or e-mail. The consent is valid until revoked; otherwise it will expire on the following date or event \_\_\_\_\_ (unless otherwise noted 60 days from issue date). Please be advised this authorization does not protect the information from being disclosed by the recipient.

Date of information issue \_\_\_\_\_

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_  
Therapist Date