TOUCHSTONE COUNSELING SERVICES, INC.

Authorization Form
Release and Consent to Disclosure of Information

Client _____

DOB _____

I, _____hereby authorize and request that the following persons may exchange information related to my treatment:

_____ and

_____, Touchstone Counseling Services, Inc.

The information released is related to: (check all that apply)

□ ENTIRE FILE	□ PSYCHOTHERAPY NOTES	□ ATTENDANCE
□ DIAGNOSIS	□ TREATMENT PLAN	□ SYMPTOMS
□ PROGNOSIS	□ PROGRESS TO DATE	□ CLINICAL TEST RESULTS
□ MODALITY OF TREATMENT	□ MEDICATION INFORMATION	□ SESSION START/STOP TIMES

Other information _____

I authorize the disclosure of the health information described above for the following purposes:_____

In consideration of such disclosure on the part of the above named persons and/or institutions, I hereby release them from any and all liability arising therefrom.

I understand that I have the right to a copy of this authorization and that any cancellation or modification must be in writing. The consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. This consent will expire automatically one year from signing.

_____ _____

Date **Signature of Client**