NEW GROWTH
COUNSELING SERVICES

Authorization to release or Exchange Information
(This does NOT include psychotherapy notes)

Client's Name:	Date of Birth:
Address:	

I hereby authorize New Growth Counseling Services to (please initial all that apply)

☐ Release information to ☐ Gather information from ☐ Exchange information with

Name of Person or Organization:
Address:
Phone #

This information may consist of the following (Please initial each box to which consent is given):

☐ Psychological test reports

☐ Psychiatric evaluation reports

☐ Social history data; including family, education, employment, arrest, drug and alcohol information

☐ Summary of previous mental health treatments

☐ Medical information

☐ Other (specify)_____

The purpose of this disclosure is (Please initial each box to which consent is given):

☐ To determine appropriateness of treatment

☐ To develop a diagnosis and treatment plan

☐ To facilitate coordination of services

☐ At the request of the individual

☐ Other (specify)_____

I understand that no information may be forwarded by either party listed in this release to any other individual or agency without my written consent. I understand that this information may not be re disclosed by its recipient. This authorization may be revoked at any time by my written statement except to the extent that authorized persons who are to disclose the information described above have already taken action in reliance on it. It is automatically revoked 30 days after the termination of the therapeutic relationship, or under the following conditions:

This consent is given voluntarily, without coercion. Signing this form is not required to receive treatment/services at New Growth Counseling Services

_____

Client (or parent/guardian of a minor) **Date**

430 E Lauridsen Blvd. - Port Angeles, WA 98362 - 360-457-1610 - FAX 360-457-8650
502 S Still Rd, Ste 102, Sequim, WA 98382 - 360-457-1610 - FAX 360-457-8650