Release of Confidential Client Information

Name of client: _____Date of birth: _____
Social Security #: _____

I understand that the purpose of this release is to assist with my/my family's treatment by improving communication between professional service providers and the important individual(s) in my life. To further this goal, **I authorize Resilience Counseling, LLC; Laura Adamgbo, MA, LPC, NCC to obtain and/or release** the below-specified information regarding me and my child(ren) to the individual(s) listed below and/or to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.
The information to be disclosed and/or received is marked by an X in the boxes below:
❑ Medical Information ❑ Treatment plan ❑ Progress notes ❑ Treatment summary
❑ Psychological/Psychiatric evaluation ❑ Medications ❑ Other: _____

This information is to be obtained and released among these persons:
Name: _____ Relationship to client: _____
Office Phone: _____ Fax: _____
Address:_____
Email: _____

Name: _____Relationship to client: _____
Office Phone: _____ Fax: _____
Address:_____
Email: _____

Name: _____ Relationship to client: _____
Office Phone: _____ Fax: _____
Address:_____
Email: _____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire upon my discharge from treatment.

Client Signature _____ ***Date:*** _____

Therapist Signature_____ ***Date:***_____