



Authorization to Release Information

Client Name: _____ Date of Birth: _____

Client Social Security Number: _____

I hereby authorize Evolve Counseling & Consulting LLC to (check one):

obtain from the following Release to the following

Name:

Address:

The following documents/information from the records pertaining to services received

Date of Service:

The documents to be released are described or listed as:

The records are required for the specific purpose of:

I understand that my authorization will remain effective from the date of my signature until _____, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

Client Signature

Date