

BEGIN ANEW COUNSELING

DONNA VANDERKODDE, Licensed Professional Counselor

RELEASE OF INFORMATION FORM

Client Name _____ Date _____

I authorize Donna VanderKodde, LPC to (check one or both) to:

release

obtain information and records to/from the person/agency identified below:

Name/Agency: _____

Address: _____

Phone: _____ Fax: _____

Records Authorized to be Released/Obtained:

Medical/Health Records

Psychological Reports/Progress Notes

School Records

Other: _____

This information will be used for the purpose of:

Coordination of Care

Other: _____

Please initial each statement below to indicate that you have read and understand each.

This authorization will expire one year from the date of the signature below.

I understand that I can revoke this authorization at any time.

I understand that I am entitled to receive a copy of this authorization.

A copy of this authorization may be utilized with the same effectiveness as the original.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____