CROSSWAYSCOUNSELING.COM

CROSSWAYS COUNSELING & CONSULTING

CREATING NEW PATHWAYS TO BALANCED, HEALTHY LIVING

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RELEASE OF INFORMATION FORM

I, _____, authorize Dr. Peter Kahle to disclose, release, and/or obtain records regarding _____ _____ to/from:

- ☐ My physician, Dr. _____
- ☐ Family Member(s) _____
- ☐ Attorney _____
- ☐ The person who referred me _____
- ☐ Previous Therapist _____
- ☐ Psychiatrist/Psychiatric Professional(s) _____
- ☐ Other _____

Information relating to my admission, diagnosis, social history, psychological tests, social data, treatment progress, any other counseling related issue, and/or _____ _____ for purposes of evaluation and treatment covering the period of time from _____ to _____. I understand this authorization expires on _____ and can be revoked by me at any time.

_____ _____
Signature of Client/Patient Date (MM/DD/YYYY)

_____ _____
Signature of Parent/Managing Conservator/ Guardian/Legal Representative (if applicable) Date (MM/DD/YYYY)