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**The Living Well Agency, LLC**

**Authorization for Release/Exchange of Information**

This form provides your therapist with written permission to communicate with other individual providers regarding your treatment (e.g., previous treating therapist, current health care providers, parents, or school)

**Client Name(s)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release of information from The Living Well Agency, LLC to Another Person or Party Listed Below:

I authorize my therapist to release/exchange the following information to:

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released:

**(Please Check)**

\_\_\_\_\_ Screening Information \_\_\_\_\_ Counseling Notes

\_\_\_\_\_ Behavioral and Psychological Reports \_\_\_\_\_ Coordination of Care

\_\_\_\_\_ Treatment Plan \_\_\_\_\_\_ Intake and History

\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This release with be valid until the termination of treatment or authorization from client to revoke authorization.**

**Expiration date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization may be revoked at any time.

**Name of Patient, Client, or Authorized person (print)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient, Client, or Authorized person**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_