Rooted in Hope with Strength of the Spirit

Confidential Release of Information

Client's Name _____ Birthdate _____

I hereby authorize Spirit of Hope Counseling Center to exchange information regarding my counseling sessions. This could include progress notes, diagnosis, a phone consultation or sessions summary. This information is for consultation or continuity of care.

You have my permission to talk to:

_____ Professional's Name / Organization	_____ Professional's Name / Organization
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone / Fax / Email	_____ Phone / Fax / Email
_____ Professional's Name / Organization	_____ Professional's Name / Organization
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone / Fax / Email	_____ Phone / Fax / Email

I agree that Spirit of Hope Counseling Center can exchange my information with the above named professional(s) or organization. I understand that I may evoke this authorization, in writing, at any time and that upon fulfillment of the above stated purpose, this authorization will expire. In any case, this authorization will automatically expire one year from the date signed.

_____ Client Signature

_____ Date