Crystal Glenn, MA, LPCC

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Release of Information

I _____________________________authorize Crystal Glenn to release information to:

____ of __________________________________

(Name of professional) (School or Organization)

and/ or receive information from:

____ of __________________________________

(Name of professional) (School or Organization)

Contact Information ___________________________ Phone Number_____________________________

Reason for release: Coordination of Care____ Emergency Only____

Limits of release: ____

No Limits______

This release expires when the therapeutic relationship is terminated or one year from today's date: ___________, however it is revocable by client at anytime with a write request for revocation.

Client Information

Name____ Date of Birth_____________________________

Phone Number_______________________________

Address____

The authorization for disclosure of information is made with informed consent. A photographic copy of this release shall be considered as effective and valid as the original document. Clients have the right to access their record, including information released by this document, by their written request allowed by state and/or federal law.

Client (Parent/Guardian) Signature____ Date_____________