Arrow Counseling Services, LLC

ADULT AND ADOLESCENT(14YRS & OLDER) RELEASE OF INFORMATION

I, _____, whose date of birth is _____/_____/_____ hereby authorize:

_____ to disclose, when requested to do so
(Name of Organization and/or Person to Release the Information)

by Arrow Counseling Services, LLC., any and all information concerning myself with respect to any illness or injury, medical history, prescription or treatment, legal history, counseling or consultation, or psychological testing and evaluation, and written copies of any medical, counseling, or social service records.
I also authorize Arrow Counseling Services, LLC to disclose any and all information to the above organization and/or person. The only purpose(s) for the disclosure of such information is to: facilitate client's treatment, coordinate treatment services with the above named provider, or obtain corroboration of client's report of history and current behavior. I may cancel this consent of information release at any time. This document will automatically be null and void 60 days after termination of treatment with Arrow Counseling Services, LLC.A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ Date_____
Client Signature

_____ Date_____

Counselor Signature