Authorization for Release of Information by Phone or Email Communication

I, _____Date of Birth _____

agree that my Therapist_____

may contact the following on my behalf to discuss my case and my needs:

Agency	**Contact Name**	**Phone Number**

I understand that by signing this release of information, my Therapist will be contacting the person(s) or agency (ies) listed above and that the information I have provided to my Therapist, may be shared for my benefit. This authorization does not permit my Therapist to release copies of my records.

I understand that this form is valid as long as I am considered an active client with my Therapist. I understand I may cancel this authorization at any time. I must give notice of cancellation in writing.

Client Name (printed):_____

Guardian Name (if client is under 18) (printed): _____

Client Name (or Guardian) (signed): _____

Specific Information
Requested:_____

_____