Empower You Therapy & Coaching, LLC

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Release of Information

Client's Name:_____ Date of Birth:_____

Home Street Address: _____

City: _____ State: _____ Zip: _____

I authorize Empower You Therapy & Coaching, LLC, and Ania Scanlan, JD, MA to:

___ disclose information to ___ obtain information from ___ exchange information with the following people and/or agencies:

Name of Person: _____

Name of Agency (if applicable): _____

Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be Released (initial by the information you would like to have disclosed/obtained/exchanged):

___ Psychiatric history summary ___ Case / session notes ___ Verbal case consultation

___ Psychological testing ___ Social / Family history summary

___ Medical history summary ___ Financial / billing summary

___ Other: _____

The purpose of this disclosure is: _____

_____

I understand that I have the right to inspect and receive a copy of the information to be disclosed. This consent is given by me voluntarily. I understand that treatment services are not contingent on whether I sign this form. I may revoke this authorization at any time, except to the extent that information already released pursuant to this consent cannot be recalled. This consent will end one year from the date this form was signed by me, unless I indicate an earlier date or event: Date:_____
Event: _____

_____ _____
Client / Parent / Guardian Signature Date Signed