

THE JOY COUNSELING CENTER

Authorization of Release

I hereby, authorize _____ Joy Counseling Center

_____ release to _____ release from _____ exchange to written/oral

communication

____ psychiatric

____ medical

____ Psychological

____ Counseling

From the records of _____ Date of Birth _____

To _____

For the purpose of: ____ Outpatient counseling ____ Coordination with schools

____ Coordination with MD

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on _____

Client, Parent, Guardian _____ Date _____