AUTHORIZATION TO RELEASE INFORMATION

Name: _____ Date: _____

I give permission to release information pertaining to Myself, My Child or My Ward's care:

From/To:	To/From:
Evolve Counseling & Holistic Wellness, LLC	_____
Kelly Roberson, MA, LPC	_____
_____	_____
_____	_____
Phone: 517-712-9736	Phone: _____
Fax: _____	Fax: _____

I understand that appropriate information from my clinical record may be released via facsimile when needed for immediate client care.

I understand that this record may contact mental health, drug, alcohol use/abuse history, HIV, AIDS or ARC as applicable.

The purpose for this release is:

_____

Specific records/information to be released:

_____

_____

This authorization is effective: From _____ To _____.

This authorization will expire on the following date _____ or upon termination of services.

I have read or had read to me this authorization form and understand what it means.

_____

Client/Parent/Guardian Signature Relationship Date

_____

Witness to Above Signature