EVOLVE COUNSELING & HOLISTIC WELLNESS, LLC©
AUTHORIZATION TO RELEASE INFORMATION
(*SEE RETURN INSTRUCTIONS BELOW*)

Name: _____ Date: _____
(Client's name)

I, _____, give Evolve Counseling & Holistic Wellness, LLC permission to
(self, parent or legal guardian)

share pertinent information regarding _____ to the following individual(s)
(client's name)

_____.
(to whom the information is being released: Name, Address and phone number

The purpose for this release is:

This authorization is effective:

This authorization will expire on the following date:

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 (required to process)

Please return this form to Evolve Counseling & Holistic Wellness, LLC at
www.evolvecounselingoflansing@gmail.com or mail 513 Hume Blvd, Lansing, MI 48917. I do not have a fax.

Both parties must return the authorization to release information in order for any information to be released.