Release of Information

I, ____, (DOB) ______________________ give my

permission to Molly Pierce of True Self Counseling and _____________________________________

(Contact Number) __________________________ to release and exchange the following information:

Information to be <u>released from</u> True Self Counseling includes client's diagnosis, symptoms, treatment, progress, history, and/or the following:

____

Information to be <u>disclosed to</u> True Self Counseling: Not applicable unless deemed necessary by the provider, or as specifically requested:

____

The purpose of this authorized disclosure is to ensure continuity of care for the client/patient. Additional reasons for disclosure include:

____

I understand that I may revoke this consent at any time except to the extent that the action has already been taken.

____________________________________	______________________
Signature of Client	Date
____________________________________	______________________
Signature of Client	Date