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 released from True Self Counseling includes client's diagnosis, symptoms, treatment, progress, history, and/or the following:

_____

Information to be disclosed to 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