Positive Changes Counseling Center, Debbie Disney, LCSW-C, LLC

Release of Information

Client Name: ____

Parent (if client is a minor): ____

I ____ authorize Positive Changes Counseling Center and Clinical Staff to obtain information from and/or release information to:

Name of person information may be shared with	Title of person	Contact information

I understand that my records and personal information are protected under the applicable state law governing health care information that relates to mental health care. The information may not be disclosed without my consent. I also understand that I may revoke this consent at any time. This consent will be in effect until written notice is given.

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Signature of Client or Parent/Guardian of Minor Date