

Tim Stauffer Professional Counseling, LLC

6047 Frantz Rd. Ste 105, Dublin Oh 43017

Phone: (614) 949-6227

AUTHORIZATION FOR RELEASE OF INFORMATION

Client/Patient Name: _____ DOB: _____

I hereby give my permission for Tim Stauffer, MA LPCC to:

Release Information TO:

Receive Information FROM:

(Name of clinician, therapist, doctor, program, or other party)

(Address)

(Phone)

(Fax)

Specify Information to be Disclosed:

Initial Evaluation

Psychological Testing

Medical Evaluations

Educational Information

Social History

Treatment Summary

Observations/Recommendations

Clinical Impression

Other _____

All of the above

For the purpose of:

Ongoing Treatment Services

Psychological Evaluation

Consultation with therapist

Court-ordered Evaluation

Other _____

I understand the reasons for the release of this information and have been informed of the benefits or disadvantages associated with such release. Such information shall not be re-released without my consent. I give my consent freely and voluntarily. This release is valid til (date) _____, and I understand that I may withdraw my consent at any time.

Date

Client Signature

Parent/Guardian Signature

Witness Signature

Release Revoked

Date

Client Signature

Witness