TIM STAUFFER PROFESSIONAL COUNSELING, LLC
5626 Frantz Rd. Dublin Oh 43017
Phone: (614) 949-6227

AUTHORIZATION FOR RELEASE OF INFORMATION

Client/Patient Name: _____ **DOB:** _____

I hereby give my permission for Dr. Tim Stauffer, PhD LPCC-S 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*