The Blessing Haus
Kandern, DE

Authorization to Release Records

I, _____, authorize _____ to:
(Client's name) (Counselor's name)

☐ Release records to _____

☐ Receive records from _____

The Information to be disclosed is:

☐ Treatment Summary

☐ Counselor's Observations

☐ Psychological Testing Results

☐ Other (please specify): _____

Should I refuse to disclose records, the consequence would be:

_____
_____
_____

This authorization to release records will expire in 365 or by the date of

_____ *(day/month/year)*, **whichever is sooner.**

I have thoroughly read through this document and confirmed the records I want released and/or obtained. I understand my Counselor will release records to the person or institution specified, and I release the staff of The Blessing Haus from liability around the release of this information, provided these records are transmitted to the party I have specified.

_____

Client/Guardian Signature Date

_____

Counselor Signature Date