

Full Circle Counseling & Coaching
PO BOX 2677, Salem, OR 97308
(503) 588-2113

Authorization for Release of Information

Date _____

Client Name _____ DOB _____

Address _____

Client Initial _____ I authorize Elizabeth Hartshorn, MS, LPC and Full Circle Counseling & Coaching to . . .

Provide information to:

Name/Organization _____

Address _____

Phone _____ Fax _____

Information to be released and purpose:

Request information from:

Name/Organization _____

Address _____

Phone _____ Fax _____

Information requested and purpose:

I understand that specific information can be released and received from Elizabeth Hartshorn, MS LPC, Full Circle Counseling & Coaching with this consent. I can cancel this consent at anytime, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that my notice of cancellation must be in writing. I understand that information about my case is confidential and protected by federal and state law. I approve the release of this information. I understand what this agreement means, and I am satisfied with any explanations I may have requested and received.

To those receiving this information under this authorization:

This information disclosed to you is protected by federal law. You are not authorized to release it to any agency or individual not listed on this form without specific written consent of the person for whom it pertains. **If you have received this release in error, destroy it immediately and contact the sender.**

Client Signature _____ Date _____

Witness/Title _____ Date _____