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AUTHORIZATION TO RELEASE/EXCHANGE HEALTHCARE INFORMATION

Client's Name: ____ DOB: ____________________

I request and authorize INGRAM & ASSOCIATES to disclose/exchange healthcare information pertaining to my evaluation and/or counseling sessions.

Person and/or organization to which disclosure is to be made:

Name: ____

Organization: ____

Address: ____

City: ____ State: ______ Zip: ________

Phone: _____________________________________ Fax: _________________________________

E-mail Address: ____

Information to be disclosed (Purpose of disclosure): ______________________________________

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This authorization expires on: ____

____ ___________________
Client Signature Date

____ ___________________
Parent/Legal Guardian Signature Date