



Authorization To Release Information

I, _____ [Name of Client], DOB: _____, authorize Rozette Pegues (Roze Therapy) to disclose to and/or obtain from _____ the following information:

Description of Information to be Disclosed (Client should initial each item to be disclosed):

- _____ Assessment
- _____ Diagnosis
- _____ Psychological Evaluation
- _____ Treatment Plan or Summary
- _____ Current Treatment Update
- _____ Educational Information
- _____ Attendance Demographic Information
- _____ Psychotherapy Notes
- Other _____

Purpose: This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify: _____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to my counselor. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____

Client's signature: _____ **Date:** _____

Counselor's signature: _____ **Date:** _____