220 1st Ave East Kalispell, Montana 59901
(406) 471-0450
bill@walkercounseling.org
www.walkercounseling.org

Authorization and Request for Release of Information

Client Name: _____ DOB _____

I, _____, hereby authorize the release of information from:

Name(s) _____

Agency _____ phone _____ fax _____

To: William Walker LCPC and staff at Walker Counseling.

I also give my permission to: William Walker LCPC and staff at Walker Counseling to release information to the above named persons and agencies. The information to be exchanged is for continuity of care.

Additional or specific information to be released and/or obtained: _____

_____.

PROHIBITION OF DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulation (42 USC § 1320d-5) prohibits any further disclosure of this information except with the specific written consent from the person to whom it pertains. A general authorization of the release of medical or other information if held by another party is not sufficient for this purpose.

This release of information expires after 1 year, or if revoked earlier in writing by the client.

_____ _____
Signature of Client Date

_____ _____
Signature of Client's parent or legal guardian Date