# Release of Information

| Client Name: | DOB: |
|---|---|
| Address: | Phone Number: |

**I give permission for Absolute Serenity to release/receive information from:**

**Person or Agency:**
______________________________________________________________

**Address:**
______________________________________________________________________

**Phone number:**______________________________________________________________

**Fax/ Email:**________________________________________________________________

**The following information regarding the client/family: (check box)**

| | |
|---|---|
| | Initial Treatment Assessment |
| | Information regarding Progress in Therapy |
| | Treatment Plan |
| | Termination Summary |
| | Other |

**For the purpose of:**

| | |
|---|---|
| | Coordination of Services |
| | Assist in Evaluation |
| | To Provide Continuity of Treatment |
| | Other |

**I understand that I can revoke this authorization at any time, except to the extent that action has already taken place. If not revoked at an earlier date, this authorization will expire one year from the date signed. I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL, ABUSE, or MENTAL HEALTH TREATMENT.**

____________________________________________________________________________

Client Signature
Date

Parent/ Legal Guardian Print Signature
Date

Witness Signature
Date