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Authorization to Release Information

This form authorizes Transformation Counseling and Assessment Center, LLC to disclose to and/or obtain from:

____

Insert Name of Person or Organization *Phone* *Email*

For the following information:
Patient (if over 14 years of age) should initial each item to be disclosed

_________	*Assessment*	_________	*Progress in Treatment*
_________	*Diagnosis*	_________	*Demographic Information*
_________	*Psychological Evaluation*	_________	*Treatment Plan or Summary*
_________	*Psychotherapy Notes**	_________	*Other*_____________________
_________	*Discharge/Transfer Summary*		___________________________

**Cannot be combined with any other disclosure.*

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Transformation Counseling and Assessment Center, LLC. 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
This authorization is valid one year from the date signed unless otherwise specified here _________________.

Patient Signature (if over age14 years): ________________________________ *Date:* ______
Patient Name: ____
Parent/Guardian Signature: ____ *Date:* ______
Parent/Guardian Name: ____