EVANS COUNSELING

Helping you to find your inner empowerment.

Release of Information

I: _____ Date of Birth: _____

Give Kate S. Evans, LCPC permission to share:

- written information
- verbal information

With: _____ Of: _____

Address: _____

Phone: _____ Fax: _____

- my psychiatrist
- my doctor
- my school counselor
- my marriage counselor
- my individual counselor
- my previous counselor
- my hospital caseworker, counselor
- my parent/guardian
- other _____

For the purpose of:

- collaborative treatment long-term
- parenting assistance
- educational assistance
- information gathering
- assessment

This consent is valid until _____ or until one year from today's date if not specified.

I understand that I may revoke this consent at any time and that the above named person authorized to receive this information has the right to inspect and copy the information disclosed.

I understand that my refusal to consent to the release of the information specified above will prevent its disclosure to the party named.

Client: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

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