NICOLA COUNSELING SERVICES
LLC

Authorization to Release/Exchange Confidential Information

This form cannot be used for the re-release of confidential information provided to Nicola Counseling Services, LLC to other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Nicola Counseling Services to:

release to_____, obtain from _____, or exchange with _____

_____
(name of agency/individual)

the following information pertaining to myself:

_____ Treatment summary
_____ History/intake
_____ Diagnosis
_____ Psychological test results
_____ Psychiatric evaluation/medication history
_____ Dates of treatment attendance
_____ Other (specify) _____

for the purpose of:

_____ Evaluation/assessment and/or coordinating treatment efforts
_____ Other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event: _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Nicola Counseling Services, LLC Practitioner Date