Robin Reinke & Associates Counseling

COUNSELING CONSENT FOR RELEASE OF INFORMATION

I hereby authorize:

Name: _____

Telephone #: _____

Address: _____

City/State/Zip: _____

AND

□ Robin M. Reinke, LMFT
□ Rachelle Walton, APCC
□ Crystal St. John, LMFT

to exchange any psychological, cognitive, medical, or social information which may pertain to myself (print name here), _____.

The question of privacy between the above-named parties and the patient is waived. This authority extends to the furnishing of copies of all or any desired parts of the records pertaining to the above-mentioned.

You are hereby released from all legal liability that may arise from the release of the information requested.

_____

Patient's Signature Date

_____

Witnessing Therapist Date