Survival 2 Victory
Counseling Services

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize **Survival 2 Victory, Inc.** to release and disclose information from the clinical record of:

_____ _____
Client Name Date of Birth

To:

_____
Facility/Provider

_____
Address

Nature of information to be disclosed:

☐ Individual is actively attending counseling treatment
☐ Summary progress report of treatment if requested by Facility/Provider named above
☐ Other

_____
State specific nature of information to be disclosed

This authorization is valid until _____(Date)

I understand that I have the right to revoke this authorization at any time by sending written notice to Survival 2 Victory, Inc. I understand that a revocation is not valid to the extent that Survival 2 Victory, Inc. has acted in reliance on such authorization.

A copy of this release shall have the same force and effect as the original.

_____ _____
Client Signature Date

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.