

MASTERPEACE
Center for Counseling and Development
A Trusted Name in Christian Counseling

EXCHANGE / RELEASE OF INFORMATION

CLIENT INFORMATION

Client's Name: _____

Date of Birth or Social Security #: _____

Address: _____

I AUTHORIZE MASTERPEACE COUNSELING TO EXCHANGE/ RELEASE THE FOLLOWING:

_____ Acknowledgement of counseling or testing services

_____ Assessment information

_____ Treatment concerns or recommendations

_____ Progress report(s)

_____ Other _____

THE INDIVIDUAL / PROFESSIONAL / BUSINESS I WISH MASTERPEACE COUNSELING TO EXCHANGE / RELEASE INFORMATION WITH:

Name/Business: _____

Address: _____

Phone Number: _____

This release will be valid until _____ or for one (1) year from the signature date. It may be revoked by the client or the guardian in writing anytime within this time frame. Persons or agencies receiving information may not further release the information without the informed, written consent of the client. The Organization offers a copy of the signed form to the party authorizing the disclosure of information when requested.

Client's Signature: _____ Date: _____

Parent/Legal Guardian's Signature: _____ Date: _____

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MASTERPEACE Staff exchanging or releasing information:

Signature: _____ Date: _____