The Center for Counseling & Training
.09 S. 10th Street Lexington, Missouri 64067
Phone 660.259.3900 Fax 660.259.9127

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

I authorize____
(Name, address, phone of person or organization)

to receive information from and disclose information to The Center for Counseling & Training.

I understand:

- This authorization may be revoked by me in writing at any time, except any information that has already been released in response to this authorization.
- This information will be released/received only to/from the person or agency named above.
- Disclosed information may no longer be protected by the federal privacy law once the information is released.
- Authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization.
- This authorization is valid for a period of *one year* from the date it is signed *unless indicated otherwise* by me as directed below:
    - This authorization will expire on:______________________
- This authorization for the following specific information/purpose:__________________________________

  ____

____
Client Name (print)

____
Client Date of Birth

____ ____________________
Signature of Client Date

____ ____________________
Signature of Parent/Guardian/Personal Representative Date

____
Specify Relationship to Client

____
Witness