TWO ROADS COUNSELLING

Release of Information

Client Information					
Full Name:		Therapist Name:	Connie Lassiter		
Individual Authorized to Access Information					
First Name:		Last Name:		Relationship:	
Company {If Applicable):					
Street Address:				City:	
Province:		Postal Code:		Fax Number:	( ) -
Main Phone:	( ) -	Email:			

Information Authorized to Release

- ☐ Session Attendance
- ☐ Fee Information
- ☐ Progress Reporting
- ☐ Other (Detail Required):

Other Information

I, _____ authorize the exchange of information as noted between my therapist and the individual assigned above. Where necessary, I understand that this information will be used only for professional purposes and only by persons clearly concerned with the issues necessitating this release.

This authorization may not be extended to circumstances which may later require this same information for other than the originally stated purpose(s) or circumstances which require forwarding of this information to otherpersons.

I understand that I can cancel this consent at any time and that if I do not exercise this right, it will automatically expire on _____
Month/Day/Year

Signature

_____

Client Name (print) Client Signature Date