REFLECTIONS PROFESSIONAL COUNSELING, LLC
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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I, _____ (print name) give consent to Reflections Professional Counseling to release/obtain (circle one or both) information to/from the following persons/entities:

Emergency Contact Information: (Name, relationship, phone):
_____

Physician or other Mental Health Providers: (Names, relationships, phone):
_____
_____
_____
_____

Legal Entities (Parole officer, attorney, judge, DHS worker, CPS worker, etcetera)(Name, title, phone):
_____
_____
_____
_____
_____

For the purpose of: _____

This release shall expire on: _____.

Signed: _____ Date: _____

Printed: _____ Date: _____

Witness: _____ Date: _____