



www.CenterforRelationalChange.com

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Authorization for Release/Exchange of Information

This form provides your therapist at The Center for Relational Change with written permission to communicate with other individuals regarding your treatment (i.e. previous therapist, current health care provider, etc.).

I, _____, authorize _____ to release and/or exchange information about my therapy services with the following party:

Name/Relation: _____

Address: _____

Telephone Number: _____

Information to be Released or Exchanged (checked all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Intake and history | <input type="checkbox"/> Diagnosis and Treatment Plan | <input type="checkbox"/> Verbal Consultation |
| <input type="checkbox"/> Treatment Progress | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Billing and Payment |
| <input type="checkbox"/> Other (specify): _____ | | <input type="checkbox"/> All of the above |

This release shall be valid until the termination of treatment or until withdrawn in writing by the client during the course of treatment.

Client Name (please print): _____

Client Signature: _____

Parent Signature (if under 18): _____

Date: _____