Consent to Release Information

Quad Cities Counseling, PLLC
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Client Name:_____

Parent/Guardian (if applicable):_____

Information to be released:

_____
_____

Reason for release:

_____
_____

Release to:
Name

_____

Address

_____

Phone/Fax

_____

Email

_____

This release to expire:

_____

I understand that my records are confidential information and by signing this agreement only the above described information will be released to the identified party. I have the right to revoke this agreement at any time.

Signature of Client:

_____
Date: _____

Signature of Parent/Guardian (if applicable):

_____
Date: _____