True Life
DISCIPLESHIP COUNSELING

AUTHORIZATION FOR RELEASE OF INFORMATION

1) Client Name: _____ Date of Birth: _____

2) I, _____, hereby give my authorization for True Life

Counselor _____ to exchange information about me with:
(Counselor's name)

Name: _____

Address: _____

Phone number: _____

Name: _____

Address: _____

Phone number: _____

I authorize the individual(s) listed above to use or disclose a complete copy of my clinical record (if applicable), and/or give permission to discuss general matters concerning my progress while I am a client of True Life.

Signature of client: _____

Print name: _____ Date: _____