Matthews Counseling, LLC
Chester Springs, PA

AUTHORIZATION TO RELEASE AND TO REQUEST CONFIDENTIAL INFORMATION

Re: (Client Name) _____ Date of Birth: _____

Client Address:

_____

This is to authorize: _____

_____

_____

To release or obtain the following information from: (Provider) _____

____ Psychiatric evaluation	_____ Other treatment records
____ Psychological evaluation	_____ Legal information
____ Educational records	_____ Admission/Discharge
____ Medical information	____ Other: _____

This release shall remain in effect for one year from its signing or until rescinded in writing.

Date: _____ Client/Parent/Guardian Signature: _____

Provider: _____