BRIGHT SOUL
COUNSELING & WELLNESS
FIND YOUR INNER LIGHT (AGAIN).

# Release of Information

_____ _____
Name of Client Date of Birth

I hereby authorize Taryn Buffolino/ Bright Soul Counseling & Wellness to release and receive the following information concerning myself or my child:

_____ Diagnostic Evaluation Results
_____ Discharge Reports

_____ Educational Records
_____ Treatment Summary

_____ Progress Notes
_____ Any and All Records

_____ Treatment Plan
_____ Other _____

The above information is only to be released to, and/or from, the following party:

_____ _____
Name and/or Agency Phone Number

_____
Address

This information is to be used for the purpose of _____.
This authorization shall remain in effect until _____, at which time it shall expire and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

I hereby release the parties named above from any liabilities for release of this information.

Client Signature _____ Date_____

Therapist Signature _____ Date_____