REFINE
COUNSELING
REFINE THE MIND~ TRANSFORM THE LIFE

AUTHORIZATION FOR RELEASE OF INFORMATION

Please carefully read the following information before signing this form. If you do not understand the nature of the information to be released, ask your counselor. This form should be completed in full before adding your signature.

- I understand that the release of information is in my best interest and is not a required condition of treatment.
- I understand that the release of information is limited to the party named below and that it will not be passed on to anyone else or used for any other purpose other than that specified below.
- I understand that I may cancel this authorization at any time by signing and dating the original of this authorization where indicated. I understand that cancellation does not affect prior action taken under this authorization.
- I understand that a photocopy of this authorization is as authentic as the original signed authorization for release of information.

I, _____, authorize
(Printed Name)

REFINE COUNSELING and my counselor _____ to release
(Printed Name of Counselor)
information to:

Name: _____

Agency: _____

Address: _____

For purposes of _____

With the following restrictions: _____

For the period: _____ to _____

Signed: _____ **Date:** _____

Witnessed: _____ **Date:** _____

I, (print name) _____ have decided to cancel the above authorization

As of Date: _____

Witnessed: _____ Date: _____