Northern Reflections Counseling PLLC
Authorization for Release of Information

Release of Information About:

_____

Name (Client name) Date of Birth

_____

Address/City/State/Zip code Phone number

Release/Disclose Information From:	Disclose Information to:
Name of facility maintaining site Northern Reflections Counseling	
Address 505 12th Ave. W.	
City, State, Zip Virginia, MN 55792	

Purpose For Disclosure is:

_____

Information to be Disclosed: between the dates of _____ to _____

Acknowledgement of Understanding

* I understand why I am being asked to authorize the release of information.
* I do not have to consent to this authorization, but I may affect my benefits or services if I do not consent.
* I understand that this information will not be disclosed to other sources unless specifically authorized by law.
* I understand that I may revoke this authorization at any time by notifying the organization in writing.
* I understand that this authorization will expire one (1) year from the date of signing.
* I understand a photocopy or fax of this form is the same as the original.

This authorization ends on __/__/__ or one year from the date I sign it, unless law allows for a longer period.

_____

Signature of Individual Authorizing Release **date**

Relationship to Client: ___Self ___Parent of Minor ___Guardian/Conservator

_____

Printed Name **date**