RELEASE OF INFORMATION

Engage Counseling Services
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Request/Authorization to Release Confidential Records and Information

I authorize **Engage Services LLC** to disclose to and/or obtain information from,

_____
Name of person and/or organization to be involved in treatment

For the following the following client: _____ ____/____/____
(Client Name) Date of Birth

Description of Information to be Disclosed:

(Initial each item to be disclosed)

_____Assessment/Diagnosis/Treatment Plan
_____Treatment Coordination
_____Current Treatment Update
_____Medication Management Information
_____Participation/Progress in Treatment
_____Educational Information
_____Discharge/Transfer Summary
_____Other_____
_____Other_____

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare treatment operations/coordination.

Specify if other: _____

_____

Expiration
Unless sooner revoked this release will be in force for 12 months following the date of signature unless specified here ___/___/___.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to "Office Manager" at Engage Services LLC. I further understand a revocation of the authorization is not effective to the extent action has been taken in reliance on the authorization.

_____
Signature of Client Date

_____
Signature of Parent, Guardian Title Date