

Main Street Counseling Center - Sheri Golly, LCSW
Client Release Of Information

Client Name: _____ DOB: _____

I understand by signing this form, I am allowing Main Street Counseling Center, LLC and Sheri Golly, LCSW to disclose to and/or obtain information concerning the above named client to:

Name of Person and/or Institution: _____

Mailing Address: _____

Phone: _____ Email: _____

Description of information to be disclosed:

- | | |
|--|---|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Clinical Assessment |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Progress In Treatment | <input type="checkbox"/> Participation In Treatment |
| <input type="checkbox"/> Clinical Consultation | |

I authorize information to be released via electronic transfer, telephone contact, fax, email and/or mail. I understand that:

- I do not have to sign this authorization and my refusal will not affect my treatment.
- I may revoke this authorization at any time by submitting a written request.
- This authorization will expire one year from the date below.

I certify that this form has been fully explained to me and I understand its contents.

Client/Parent/Guardian Signature: _____ Date: _____

Relationship if not the Client: _____