TRAVERSE COUNSELING & CONSULTING

Traverse: To pass over, along or through

Client's Name: ____ Date of Birth: _____________

1. I authorize____,

   of Traverse Counseling & Consulting, GBC, to release/exchange information with:

   Person/Organization: ____

   Phone: _______________________________ Fax: _____________________________________

   Email Address: ____

2. The purpose for which this information may be used or disclosed: ____________________________

3. Information you may use and disclose: ☐ Entire Record ☐ Mental Health Records

   ☐ Other: ____

4. This information expires on the following date, event or condition: ___________________________
   Note: If date, event or condition is not specified, this authorization expires twelve months from the date I sign this form.

I understand that I may revoke (end) this authorization at any time by notifying, in writing, the facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. I have the right to inspect or copy the health information to be used or disclosed. If the disclosed information goes to a health care provider covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed. I do not have to sign this authorization form. Treatment and payment of services is not contingent on me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as for life insurance companies.

I hereby acknowledge that I have read, or have read to me and fully understand the above statements as they apply to me and do herein consent to disclosure for the purpose stated above.

Client signature: ____ Date: __________________

If signed by client representative, Name/Relationship_______________________________________

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