



TRAVERSE COUNSELING & CONSULTING
Traverse: To pass over, along or through

Client's Name: _____ Date of Birth: _____

I authorize _____ and _____
(if second provider)

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

Person/Organization

Phone # Fax #

Email Address

The purpose for which this information may be used or disclosed: ☐ **Billing/Scheduling Purposes**

☐ **Coordination of Care** ☐ **Other:** _____

Information you may use and disclose: ☐ **Billing/Scheduling Purposes** ☐ **Entire Record**

☐ **Mental Health Records** ☐ **Other:** _____

This information expires on the following date, event or condition: _____ (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 has been 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

Printed Name

Relationship to client, if signed by client representative/guardian