VOGT PROFESSIONAL COUNSELING SERVICES

"Finding Hope, Courage & Freedom"

RELEASE OF CONFIDENTIAL INFORMATION

Client's Name _____

Birthdate _____

I hereby authorize **Vogt Professional Counseling Center** _____ and:
(Therapist's Name)

_____	_____
Professional's Name/Organization	Professional's Name/Organization
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
Phone	Phone

To exchange the following information (check all that apply):

_____ Phone Consultation	_____ Discharge Summary
_____ Social History	_____ Treatment Plan
_____ Diagnosis	_____ Medical History
_____ Psychological Tests	_____ Chemical Dependency Evaluation
_____ Progress Notes	_____ Other _____

This information is needed for the following purpose:

1. To effect a continuum of care for the client's recovery
2. Other _____

I understand that I may revoke this authorization, in writing, at any time and that upon fulfillment of the above stated purpose, this authorization will expire. In any case, this authorization will automatically expire one year from the date signed.

_____	_____
Client Signature	Date
_____	_____
Client Signature	Date

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