VOGT PROFESSIONAL COUNSELING SERVICES

"Finding Hope, Courage & Freedom"

RELEASE OF CONFIDENTIAL INFORMATION

Client's Name _____

Birthdate _____

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

_____
Professional's Name/Organization

_____
Address

_____
City, State, Zip

_____
Phone

Email:_____

_____
Professional's Name/Organization

_____
Address

_____
City, State, Zip

_____
Phone

Email:_____

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

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