

JOURNEYS COUNSELING MINISTRY

RELEASE OF INFORMATION

<b>Client Information</b>		
Name:		Age:
Street:		
City:	State:	Zip:
Home Phone:	Work Phone:	
<b>I Authorize</b>		
Therapist's Name:		
<input type="checkbox"/> <b>To Obtain From:</b>		
ATTN:		
Agency Name:		
Street:		
City:	State:	Zip:
Phone:	Fax:	
<input type="checkbox"/> <b>Or Furnish to:</b>		
ATTN:		
Agency Name:		
Street:		
City:	State:	Zip:
Phone:	Fax:	
<b>The Following Information Contained In My Medical Records:</b>		
<b>Purpose of Request:</b>		
<b>Authorization</b>		

This authorization is valid for six months from the date below. I understand that this information may not be released to any other organization without my permission. I release the source of these records from any liability arising from their release. A photocopy of this authorization shall be considered valid.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date