Gary Cochran MA, LPC-S

Campbell Counseling Group, PLLC

Authorization for Release of Confidential Information
(as needed)

I, ____, Date of Birth: ____________________,
(Client's Name and or/Legal Guardian) hereby authorize Gary Cochran, MA, LPC-S, to release information to and receive information from:

____

(Person/Organization) (Telephone number)

____

(Address)

I understand that the purpose of the disclosure is to comply with my request for Gary Cochran, MA, LPC-S to disclose information. The information to be disclosed includes –

( ) All mental health records ( ) Other ____________________________________

( ) Progress in Treatment

( ) Diagnosis

( ) Treatment Plan

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be re-disclosed by the recipient named above and at that time would no longer be protected by Gary Cochran, MA, LPC-S. I agree that a photocopy or facsimile of this authorization is as valid as an original. This authorization for release of information will expire one year after the date it was signed.

Date: __________________________________

______________________________ __________________________________

Printed name of Client Signature of Client

Printed name of Witness	Signature of Witness
Printed name of Parent/Guardian	Signature of Parent/Guardian