

Client Name:

Medical Record#:

Medicaid #:



Cascade Counseling & Consulting, PLLC

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ (_____) authorize
(Name of client) (Date of Birth)
Cascade Counseling & Consulting, PLLC to release and disclose
information to and allow such information to be inspected and copied by:

(Facility/Provider)

(Address)

(Phone/Fax)

For the purposes of _____
(State specific purpose of information to be disclosed)

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Cascade Counseling & Consulting, PLLC. I understand that a revocation is not valid to the extent that Cascade Counseling & Consulting, PLLC has acted in reliance on such authorization. This authorization is valid for one year from the date of signature.

A copy of this release shall have the same force and effect as the original.

(Client Signature)

(Date)

(Parent/Guardian Signature)

(Date)

(Parent/Guardian Signature)

(Date)

(Witness Signature)

(Date)