Living Well
COUNSELING SERVICES, LLC

1532 W Broadway #201
Monona, Wisconsin 53713
Phone 608-223-1506
Fax 608-223-1745
www.lwcounseling.com

Authorization for Release or Exchange of Information

_____ of Living Well Counseling Services, LLC. is given my permission to:
(Name of Therapist)

☐ release to: ☐ obtain from: ☐ exchange with:

Name of individual, agency, program: _____

Address: _____

_____

Phone: _____ Fax: _____

Information regarding:

_____ _____
Print Full Name of Client Date of Birth

I understand that the purpose or need for release of this information is to aid in providing and coordinating assessment, treatment, and after-care services. I have checked all specific information below that is being requested:

☐ Counseling records ☐ Other_____

I understand that my records are protected under Wisconsin State Statutes governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in State Statutes.
I understand that my consent may be revoked by me at any time, except to the extent that action has already been taken. This consent expires one year from this date unless expressly revoked earlier by the methods listed below. I hereby release you and Living Well Counseling Services, LLC from all legal responsibility or liability that may arise from this act.

1) Sign and date a revocation form. This form is available from your therapist.
2) Write, sign, and date a letter to your therapist to cancel authorization.
3) Sign, date, and write “CANCEL” on this original form.

Once your therapist releases information, he or she has no control over action by the recipient (including re-releasing) of your records.

_____ _____
Signature of Client **Date**

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Witness Signature **Date**