Ability Counseling, LLC
8853 Fox Dr., Suite 105
Thornton, CO 80260

PERMISSION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Ability Counseling, LLC to:

[ ] disclose information to [ ] receive information from [ ] exchange information with

Name(s): _____ Phone #: _____

Name or Agency Name: _____

Regarding: _____ Client Phone: _____
(Client Name – please print)

Client Address: _____
(street) (city) (state) (zip)

DOB: _____

The information to be disclosed is:
[ ] Attendance information
[ ] Summary of treatment
[ ] Treatment Plan
[ ] Past Treatment Records
[ ] Psychological Evaluations
[ ] Progress Reports
[ ] Discharge Reports
[ ] Other (specify) _____
_____
_____

The purpose of this disclosure is for:
[ ] Further treatment
[ ] Consultation
[ ] Withdrawal/Readmission process
[ ] Other (specify) _____
_____

This consent is effective on _____ and expires on _____.

I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

Client Signature: _____ Therapist Name: _____

Parent/Guardian Signature:_____

NOTICE*: This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. (However, there are legal and ethical requirements that counselors take responsible action in those situations as prescribed by law 1) where there is danger of imminent harm to self or others, and 2) in the case of apparent child abuse.)*