Two-Way Release Of Information

On behalf of myself or my minor child, I authorize East Counseling Services, Inc. (ECS) and:

Provider's Name: _____

Business Name: _____

Address: _____Suite: _____

City" _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

. . . to release to each other for the purpose of coordination of services, verbal communication and/or written reports regarding diagnosis, treatment, prognosis, or recommendations, as well as other data pertinent to the treatment of:

Name of Client: _____ Client's Date of Birth:_____

I understand this consent to release information is valid for a period of twelve (12) months from the date it is given and that I may withdraw this consent at any time by requesting, in writing, that the consent be withdrawn.

In consideration of this consent, I hereby release the above named parties from any legal liability resulting from this Two-Way Release of Information.

Date: _____ Signature of Authorized Person: _____

Printed Name of Authorized Person: _____

Cell Phone: _____ Other Phone: _____

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