

Sean D. Davis, Ph.D., LMFT

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Authorization for Release of Information

Client Name(s): _____

Date(s) of Birth: _____

This statement authorizes Dr. Sean Davis to release and/or exchange information with the following individuals and/or organizations:

Name: Address: Phone:	Client Initial
Name: Address: Phone:	Client Initial
Name: Address: Phone:	Client Initial

This information may consist of the following:

- Summary information regarding therapy experience including clinical opinions, assessments, and histories.
- Summary consultation information from ecclesiastical leaders or previous counselors.
- Other: _____

This information will be used for the following purpose(s):

- Further mental health evaluation and treatment.
- Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

- Do not release.

I understand that I may revoke this authorization by writing at any time and that this release will be good from one year after the date of signing unless otherwise specified in writing. I (we) have read the foregoing with respect to the sharing of this personal information between the mentioned parties and agree to these conditions.

Signed (Client or Guardian)

Signed

Therapist

Date