Client Information:

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Health Care Provider (with information to be released):

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

Receiving Party (Seeking information to be released):

Name: Jesse Lile, PhD, LPC, LMFT **Relationship to Client:** Providing counseling services

Address: Suite 210 (building 200), Oak Summit Office Park, 895 State Farm Rd

City: Boone **State:** North Carolina **Zip Code:** 28607

Phone Number: (828) 276-3023

Are there any stipulations/restrictions regarding the information to be released?

Yes / No

If so, list out these stipulations/restrictions: _____

_____

Signature of Client: _____ Date: _____

Signature of Provider: _____ Date: _____

I (the client) authorize the release of information according to the terms described above. I understand that this release of information will last for one year from the date of signing, unless I enter another date of expiration here: _____. I also understand that I can refuse to sign this authorization and that such refusal will not affect my treatment. A copy/fax of this authorization can be treated as the original copy.