Transitions Counseling Services, Inc.
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AUTHORIZATION FOR THE RELEASE OF INFORMATION

In order to ensure quality and continuity of care, the above referenced Practice and its authorized representatives, including treating provider(s), may communicate with other doctors, therapists, family members, friends, teachers, etc. who may be able to provide useful information. It may also benefit you to have these individuals apprised of our current and/or past work together. The above referenced Practice requires your written permission before communicating with any individual(s). This permission may be discontinued at any time in the future, please indicate the date of expiration below. If no date is indicated, this release of information will expire 2 years from the date of authorization.

I hereby give my consent to Transitions Counseling Services, Inc. to exchange information pertaining to my medical, educational and/or mental health history (including substance use) with the following individual or organization:

Name: _____

Location: _____

Telephone Number: _____

_____ _____
Patient Name (please print) Date of Birth

_____
Patient/Guardian Signature

_____ _____
Date Expiration Date (optional)