

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Name of Client) _____ (Date of Birth),

Authorize the verbal and/or written release and exchange of my confidential medical, psychological, psychiatric, vocational, and/or other information as appropriate

Between the following specific individuals / organizations:

- From To Cobb Counselling & Consulting Services: Nathan Cobb, Ph. D.
- From To Spouse/Partner/Family Member: _____
- From To Health Care Professional: _____
- From To Lawyer: _____
- From To Insurance Company: _____
- From To Employer: _____
- From To Ecclesiastical Leader: _____
- From To Other: _____

Subject to the following exclusions and limitations:

I understand that I may revoke this consent at any time by informing the above parties in writing.

(Client Signature)

(Date)

(Client Signature)

(Date)

(Parent or Guardian Signature, If Required)

(Date)

(Witness Signature)

(Date)

This release of information remains in effect for one year from the date of signature unless otherwise notified