Release of Information

Valor Counseling Center, PLLC

352B Raleigh St. | Holly Springs | NC | 27540

919.762.6522

Name: _____ **Date:** _____

I, the client or authorized guardian, authorize the release of the following information to:

_____

(medical provider/medical office/other) & (address/phone/fax)

on: _____.

(date)

The Protected Health Information I give consent to share is as follows *(please initial):*

____ Billing ____ Progress Notes ____ Other

____ Telephone Conversations ____ Evaluations/Assessments

____ Scheduling ____ Treatment Summaries

_____ _____

Signature of Client or Parent Guardian Date

_____

Clinician Signature & Date