



## CONSENT FOR RELEASE OF INFORMATION

CLIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize Rebecca Frock or any member of Rebecca Frock Counseling who has examined or treated me, to release or obtain any and all information concerning my physical and/or psychological condition, care and treatment to/from the institution(s)/individual(s) named below:

\_\_\_\_\_  
NAME PHONE

\_\_\_\_\_  
ADDRESS CITY ST ZIP

\_\_\_\_\_  
CLIENT SIGNATURE DATE

\_\_\_\_\_  
NAME PHONE

\_\_\_\_\_  
ADDRESS CITY ST ZIP

\_\_\_\_\_  
CLIENT SIGNATURE DATE

This Consent for Release includes, but is not limited to psychological reports, psychological testing an evaluation, clinical notes, subjective and objective complaints, diagnosis and prognosis, and any other documents, records, or information relative to my past, present, or future physical and/or psychological condition.

I hereby expressly waive any laws, regulations and rules of ethics that might prevent Rebecca Frock Counseling from releasing or obtaining such records. A photostatic copy of this authorization, which contains my signature, shall be considered as effective and valid as the original.

\_\_\_\_\_  
CLIENT SIGNATURE DATE

\_\_\_\_\_  
LEGAL GUARDIAN SIGNATURE DATE