



Release of Information

CLIENT: _____ **DATE:** _____

I hereby authorize, _____ to disclose and/or
NAME OF THERAPIST/PSYCHOLOGIST

mutually release and exchange the information in my records with the following person(s):

NAME: _____ **CONTACT:** _____

NAME: _____ **CONTACT:** _____

I give my permission for the following to be exchanged/released for the purpose(s) stated. (please place initials next to the appropriate description of information desired for release/exchange.)

_____ All information about ongoing treatment for continuing counseling considerations

_____ Financial/Billing for solely billing purposes

_____ Other (please describe below; include the purpose of request)

I understand that this ROI is subject to revocation to me in writing except to the extent that action has been taken on it. According to state law, this release expires one year from the affixed date or at the termination of counseling. I hereby release from all legal liability that may arise from mutual exchange/release of the requested information. Imani Behavioral Health, the above-named Imani Behavioral Health therapist, and the above named third party/organization.

NAME OF CLIENT OR GUARDIAN/PARENT

SIGNATURE

NAME OF WITNESS

SIGNATURE