Orlando Counseling Services

Authorization of Release

I hereby, authorize _____ Orlando Counseling services

_____release to _____release from _____exchange to written/oral communication

____psychiatric

____medical

____Psychological

____Counseling

From the records of _____Date of Birth _____

To _____

_____

For the purpose of: ____Outpatient counseling ____Coordination with schools

____Coordination with MD

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on _____

Client, Parent, Guardian _____ Date _____