JOURNEYS COUNSELING MINISTRY

RELEASE OF INFORMATION

Client Information		
Name:		Age:
Street:		
City:	State:	Zip:
Home Phone:	Work Phone:	
I Authorize		
Therapist's Name:		
❑ **To Obtain From:**		
ATTN:		
Agency Name:		
Street:		
City:	State:	Zip:
Phone:	Fax:	
❑ **Or Furnish to:**		
ATTN:		
Agency Name:		
Street		
City:	State:	Zip:
Phone:	Fax:	
The Following Information Contained In My Medical Records:		
Purpose of Request:		
Authorization		

This authorization is valid for six months from the date below. I understand that this information may not be released to any other organization without my permission. I release the source of these records from any liability arising from their release. A photocopy of this authorization shall be considered valid.

_____ _____

Client Signature Date

Revised 7.16.2002

P.O. BOX 10670 • COSTA MESA, CA • 92627-0216

714-957-1973