



**Release of Information**

\_\_\_\_\_ authorizes the release of information between

Client Name/Legal Guardian

\_\_\_\_\_  
Therapist

616-607-6355

www.alliancecares.care

**AND**

\_\_\_\_\_  
Name of Person/Organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax Number

to exchange information between themselves contained in the personal records of:

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Date of Birth

The specific information to be disclosed: \_\_\_\_\_

The type of disclosure (check all that apply):

Verbal Exchange of Information

Written Exchange of Information

Faxed Exchange of Information

I am aware that I may revoke this authorization at any time by notifying in writing the person(s) authorized above.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date



I hereby REVOKE my authorization of releasing confidential information between the parties listed above.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date