



Release of Information

1543 Lake Baldwin Lane
Suite B
Orlando, FL 32814

Phone: 407-894-5202
Fax: 407-894-5620
E-mail: info@chariscounselingcenter.com

Name:
Address:
Phone:
Date of Birth:
Social Security Number:

I authorize _____ [therapist's name] and Charis Counseling Center
to release and/or obtain information to/from:

Name of Person or Organization
Address
Phone/Fax
Email Address:

I authorize information to be released by the following methods of communication:

Phone Fax Email Mail

I understand that:

- I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment
- I may **revoke** this authorization at any time by submitting a written request to Charis Counseling Center.
- This authorization will expire on: _____

I certify that:

This form has been fully explained to me and I understand its contents.

Client Signature

Date

Witness Signature

Date