Release of Information

Have you previously sought counseling? Yes_____ No____
If yes, please provide the following:

Counselor's name_____ Phone_____

Are you under the care of a physician? Yes____ No_____
If yes, please provide the following:

Physician's name_____ Phone_____
Cardiologist's name_____Phone_____
Psychiatrist's name_____Phone_____

Are you under the care of a dietician? Yes____No___.
If yes, please provide the following:

Dietician's name_____Phone_____

AUTHORIZAATION TO RELEASE INFORMATION:

I hereby authorize the release of pertinent information acquired in the course of my treatment, as necessary, to process insurance claims, to maintain medical records, or in reference to other psychotherapy. I also hereby authorize therapist to contact previous counselors/therapists and/or physicians if therapy deems it necessary to facilitate treatment.

Signature_____

Date_____