SoulSpring Counseling Inc.

Group Psychotherapy Practice

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Authorization for Release and/or Exchange of Information

I, ______________________________________, hereby grant permission for SoulSpring Counseling Inc. to __________ Release and/or _____ Obtain confidential information with the following person/organization:

Name: ____

Address: ____

____

Phone: ____

Purpose of Release: ____

My signature below authorizes SoulSpring Counseling Inc. to ___________ Release and/or _____ Obtain confidential information concerning my mental health treatment for an indefinite amount of time. I understand I may revoke this consent either verbally or in writing at any time.

Therapist Signature: _________________________________ Date: ____________________

Client Signature: _________________________________ Date: ____________________