

Release of Information with Consent of Client

Grace Layton, LLC. 8310 Allison Pointe Blvd. Suite 103, Indianapolis, IN 46250. Ph. 317-622-6544

Therapist's printed name and place of work if different than the header

I, _____, authorize Grace Layton LLC to release/obtain information pertaining to my evaluation and or therapy sessions to the below identified person/organization:

Name of person and title of organization, phone

Address

I hereby authorize Grace Layton LLC to Release and/or Obtain the following:

<u>Release</u>	<u>Obtain</u>
_____ Diagnosis & Evaluation	_____ Diagnosis & Evaluation
_____ Discharge/Termination Summary	_____ Discharge/Termination Summary
_____ Entire Client Record	_____ Alcohol/Drug Related Info
	_____ Psychological/Psychiatric Testing
	_____ School Records
_____ Informal Communication	_____ Informal Communication
_____ Other Pertinent Information	_____ Other Pertinent Information

Explain: _____

For the purposes of: _____

I, _____ understand that authorization shall remain valid from the date of my signature below until the termination of therapy or until I revoke this authorization by written or oral communication to Grace Layton at any time.

Client's Name / Date of Birth

Signature of Client (parent or legal guardian) / Relationship to Client / Date of Consent

Signature of Witness and Title of Witness Obtaining Consent / Date of Consent