4600 Kietzke Lane
BLDG G-177
Reno, NV 89502
775-622-8890
Fax: 775-622-8920

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Client Name:____________________________________

I, ____, hereby authorize Silver State Counseling and Therapy to disclose information and records obtained in the course of my diagnosis and/or treatment to:

____
Name/Entity to whom disclosure is made

____
Address

____
Phone/Fax

Silver State Counseling and Therapy may release my information to the above person/entity in the following forms (please initial) _________ Verbal _________ Written

Disclosure of information and records may be released for the following purposes:

- ☐ Treatment recommendations and progress
- ☐ Treatment coordination
- ☐ Referral
- ☐ Assessment and diagnosis
- ☐ Therapy attendance
- ☐ Treatment Plans
- ☐ Other:___________________________
- ☐ All/Any

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This authorization shall remain valid for 1 year after last date of service unless otherwise indicated here: This release is valid until: __________________

Client/Guardian Signature: ________________________________ Date: _________________
Relationship to client________________________________