Reciprocal Consent to Release/Receive Confidential Information

**I/We, , give my/our informed consent for D’Amico & Associates in Counseling to release and receive confidential information to:**

Name of Professional/Guardian ad Litem/Attorney to receive information:

Phone: ()- Fax: ()-

Agency Name:

Address:

City:  State:  Zip Code:

**For the purpose of coordination of services.**

Client Name: DOB://

Street Address (include apt/unit # if applicable):

City: State: Zip Code:

**This consent is valid for one (1) year from today’s date, unless revoked in writing.**

I have read and understand the purpose of this release is to coordinate treatment services.

Client Signature: Date: //

Parent/Guardian Signature: Date: //

Witness Signature: Date: //