Counseling for New Dimensions, LLC

8935 N. Meridian Suite 107
Indianapolis, Indiana 46260
317-571-0170 ext. 119

Client's Authorization for Exchange of Information

Client's Name(s) __________________________________ SSN or DOB: _____________________

Address ____

City ____________________________________ State _________ Zip ___________________

Organization(s) or person(s) with whom information will be exchanged between:

Gary Conway, LMHC
8395 Meridian St. Suite 107
Indianapolis, IN 46260

AND

Agency or Person ____ Phone __________________

Address ____ City ________________ State ___ Zip ______

(Please check how information will be exchanged, one or both lines below)

Information will be **requested** from the person ___
Information will be **released** to the person ___

Description or list of information to be exchanged:

I consent to the release of the above described information and I understand this information shall be kept confidential and shall be used for the purpose of planning and delivering my services. I understand that I have a right to see this information at any time. This consent is valid for information already in existence and any information, which may be generated during the future service involvement, unless restricted in writing. I understand that I can revoke my consent at any time by providing written notification. This consent shall expire upon termination of services, or on the date specified below by the authorizing party. I have read this form, or it has been read and explained to me, and I understand its content.

A photocopy of this signed Authorization shall have the same force and effect as this original.

Client Signature (or Parent/Guardian) Date Relationship to Client Expiration Date

Therapist Date