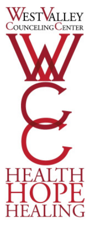

West Valley Counseling Center
Teri Cole, LPC
Toni Durda, LAC
13260 N 94th Dr
Ste 106

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name	Client Name

I (we) do hereby authorize and consent that you release my information to the following:

Insurance Company Name	Phone	Client's Initials
Name	Phone	Client's Initials
Name	Phone	Client's Initials
Name	Phone	Client's Initials
Name	Phone	Client's Initials

I do release and disclose to West Valley Counseling Center, PLLC or its representative all information, including, without limitation, records, documents, reports, testing reports, human immunodeficiency virus test reports, human immunodeficiency syndrome test reports, opinions, assessments, histories and clinical abstracts of every kind and description, relating to my social, emotional, educational, psychological and medical condition and any care and counseling which I received from you or your representatives. I also authorize you to release and exchange copies of all files and documents which contain said information.

In furtherance of this authorization, I do hereby waive any privilege and right of privacy and right of privacy relating to any disclosure hereby authorized. I understand that this authorization will remain in effect until I cancel it by written notice to you. A photocopy of this authorization shall be accepted as granting the same authority as a signed original.

Client's Signature	Date
Client's Signature	Date
Witness	Date
If under 18 years of age, signature of parent or legal guardian	Date

Parent or legal guardian's street address	City	State