

WATERSHED
COUNSELING AND CONSULTING

Kayla Slater, M.A., NCC.

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Authorization for Release of Information

I, _____ authorize Keelin DeGeorge, M.Ed to:

(patient or guardian)

(initial) _____ provide information as indicated: _____

(initial) _____ exchange information as indicated: _____

(initial) _____ receive information as indicated: _____

regarding _____ treatment and status to/with/from:

(patient's name) (circle)

Any specific information that should be admitted? _____

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

I understand that I may revoke this consent at any time by written request to the authorized person. The revocation is effective on the date the request is received and placed in the medical record.

Patient's DOB ____ /____ /_____ and

Signature Date (Patient or Guardian) _____

Keelin DeGeorge, M.Ed