WESTERVILLE COUNSELING GROUP
33 E. SCHROCK RD., SUITES 22-23
WESTERVILLE, OHIO 43081

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, Date of Birth _____________, hereby authorize my counselor, Robert D. Rubinow II, to release my information to:

Specific Identification of Person or Entity Authorized to Receive Information

I authorize the following information to be released:

- ☐ All Clinical Records
- ☐ History and Physical
- ☐ Treatment Plan
- ☐ Consultation
- ☐ Narrative Summary
- ☐ Psychological Evaluation
- ☐ Therapy Progress Notes
- ☐ Other: _________________
- ☐ Psychiatric Examination
- ☐ Assessments
- ☐ Lab Results

I, ____, Date of Birth _____________, hereby authorize my counselor, Robert D. Rubinow II, to receive my information from:

Specific Identification of Person or Entity Authorized to Send Information

This authorization for use/disclosure is for the following purpose: ____, and will remain in effect for 90/180 days (circle one) unless an earlier date or condition/event is specified here: ____________________________. I understand that I, or my legal guardian, have the right to revoke, in writing, this release of information at any time.

____ _______________

Client Signature Date

____ _______________

Counselor Signature (Witness) Date