



## GROWTH & GRACE, LLC

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### Release of Information

*Please be aware the age of consent for mental health counseling services in New Jersey is 16 years old. **If you are 16 years or older, please utilize your signature on this form.***

I \_\_\_\_\_ (Your Name) hereby authorize the release and disclosure of the following clinical and/or therapeutic records belonging to \_\_\_\_\_ (Name of client) for the following purpose:

Please initial next to all that apply:

\_\_\_\_ Authorization to release information regarding counseling and therapy care and treatment

Specific information to be released (please initial all that apply):

\_\_\_\_ Psychosocial history

\_\_\_\_ Discharge summary

\_\_\_\_ Attendance

\_\_\_\_ Billing information

I authorize the release of information between Growth & Grace, LLC and

\_\_\_\_\_ (Name of Organization/Business/Practice/Person)

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_



Revocation/Expiration: This Release of Information is subject to revocation by the undersigned at any time except to the extent that information has already been disclosed based on authorization contained herein. This Release of Information will automatically expire after a period of 1 year from the date signed. I have the right to receive a copy of this Release of Information upon my request.

Expiration Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

