Grief Recovery Center
4939 Jamestown Ave., Suite 101
Baton Rouge, LA 70808
Phone: 225-924-6621 Fax 225-924-6627
www.grcbr.org

RELEASE OF INFORMATION

I, _____, understand
(Print Name)

that during the course of my treatment in may become necessary for the Grief Recovery Center to consult with professionals, e.g. physicians, other counselors, or others, e.g. family members, regarding my case.

Therefore, I hereby authorize the Grief Recovery Center and the following person(s)

Please Print: Name(s) Address(s) Phone Number(s)

_____

_____

_____

_____

to consult with each other regarding my case and to disclose information necessary to the consultation, including but not limited to,

Presenting Problem, History, Diagnosis, Treatment, Dates of Service, and Prognosis

Additional information I authorize to be released _____

_____

This authorization may be revoked in writing by me at any time except to the extent that action has been taken in reliance upon it.

This Release of Information shall remain in force for one year from date signed, unless otherwise revoked in writing.

_____ _____
Signature of Client, Parent, Guardian, or Legal Representative Date