Allura Sex Therapy Centre

Consent to Release/Exchange of Information

I, _____, hereby request and authorize _____ at *Allura Sex Therapy Centre* to release a copy of my file to the person or agency below.

Name	*Position*	*Agency*	*Contact Information*

Date of authorization: ___//___//_____
Authorization will expire on ___//___//_____ or one (1) year after the date of authorization if unspecified.

Information to be released:

- ☐ Family and Social History
- ☐ Medical History
- ☐ Psychological Information/testing
- ☐ Diagnosis
- ☐ Substance Abuse Records
- ☐ Educational Records
- ☐ Progress Notes
- ☐ Treatment Plan/progress
- ☐ Discharge Summary
- ☐ Other as Specified _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Allura Sex Therapy Centre. I understand that a revocation is not valid to the extent that Allura Sex Therapy Centre has acted in reliance on such authorization. This authorization is valid until one year from date signed unless revoked earlier. I understand that information will be disclosed only as determined necessary by my therapist. If records are released to lawyers in legal proceedings, I understand that information is usually shared with any and all parties in involved in the legal proceedings. In consideration of this consent, I hereby release the source of the records fom and all liability arising therefrom.

_____ _____

(Client signature) (Date) (Witness Signature) (Date)