Genesis Counseling Services, Ltd.

One South Main St. * P.O. Box 8010 * Janesville, WI 53547-8010 * 608-757-0404 * Fax 608-757-2319
www.genesiscounselingservices.com

Authorization for Release of Information

Client Name: ______________________ Date of Birth: ______________________

Address: ______________________ Phone: ______________________

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I hereby authorize Genesis Counseling Services to:

- ☐ Disclose information from my case record to:
- ☐ Obtain information from:
- ☐ Have verbal exchange with
- ☐ Have e-mail exchange with:

Name: ______________________ Phone: ______________________

Address: ______________________ FAX: ______________________

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Type of information to be disclosed: ______________________

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Purpose for disclosure: ______________________

____

Information from the past two years will be disclosed, unless otherwise specified: ________ **to** ________

Expiration Date: This authorization will remain in effect until the above disclosure has been completed unless otherwise specified:

- ☐ Other specific expiration date: ______________________
- ☐ Other specific expiration event: ______________________

I understand that:

I have the right to inspect or receive a copy of the material to be disclosed, and that I may be charged a fee for record copies. I am under no obligation to sign this form, and treatment may not be conditioned on my signature. I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Genesis Counseling Services. Disclosed information may be subject to re-disclosure and is no longer protected by federal privacy law.

______________________ ______________________

Client/Representative Signature / Date **Staff Signature / Date**

If signed by a Representative:

☐ Parent ☐ Legal guardian ☐ Other ______________________