Silver Lining Counseling Services LLC
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CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I authorize_____,

Address:_____Phone_____

and Elizabeth Ross LMFT LPC to exchange information relating to:_____

The following information may be released_____

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for the purpose of facilitating therapy.

The information disclosed through this release will NOT be released to other person or persons without written authorization from the above named client(s).

I have read and understand this release and certify that this consent for disclosure has been made voluntarily. Photocopies of this authorization are to be given the same effect as the original.

Date_____

(Client Signature)

(Signature of Legal Guardian if client is a minor child)