Daniel Rothman, MA, LPC
PO Box 533
Ketchum, ID 83340
208.481.4838

Release of Information

Name: _____

Date of Birth: _____

I give Daniel Rothman, MA, LPC permission to disclose information concerning my treatment or that of my child _____ to:

Name: _____

Address: _____

_____

Phone Number: _____

I understand and authorize that I am giving my permission to release social, psychological, educational, and medical information for the purpose of (indicate specific reason): _____

_____

_____

_____

I have been informed that I may revoke this authorization by written or oral communication. I certify that this form has been fully explained to me and that I understand its contents.

Client/Parent _____ Date: _____

Counselor _____ Date: _____