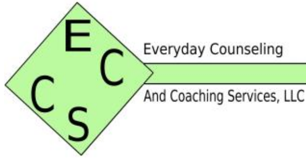

Everyday Counseling and Coaching Services, LLC
Orly Katz, LCPC, NBCC
1 Research Court. Suite 450
Rockville, MD 20850
(301) 660-6759
therapyorly181@gmail.com

Authorization for Release of Confidential Information

Client information:

Name: ____

Address: ____

Telephone number: ____

Release of information:

I hereby authorize Everyday Counseling and Coaching Services, LLC (ECCS) to/from:

___Release ___Obtain ___Exchange medical and/or mental health information of the above client.

For the following purpose ____

To/from:____

Address:____

Phone number:____

This authorization will expire one year from the date signed below unless specific expiration event occurs. This authorization covers treatment only for the dates specified above. I understand I have the right to refuse to sign this authorization. I need not sign this authorization form in order to assure treatment.

I _________________________have read the above and authorize ECCS and the staff of the facility/organization to which disclosure is to be made to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time.

________________________ ______________________________________

Date Signature of Client