Everyone Needs a Little TLC
Total Life Counseling Center

Individual, Family, Marriage & Group Counseling
P: 407-248-0030
F: 407-248-0226
Satellite Locations:
Clermont & Winter Park

Release of Information

I, _____, hereby authorize Total Life Counseling Center, 1507 S. Hiawassee Road, Orlando, FL 32835 to:

_____ Release To _____ Release from _____ Exchange Written and/or Oral Communication

_____ Psychiatric _____ Medical

_____ Psychological _____ Counseling

from the records of: _____ _____
Name of Client Date of Birth

To: _____

_____

For the purpose of: ☐ Outpatient Counseling ☐ Coordination with schools
☐ Send Thank You Card for Referral
☐ Coordination with MD/Psychologist/OT Therapist/Therapist

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on _____

_____
Client, Parent, Guardian Date

_____
Witness Date This form is to document that I,
_____, give my permission and
PRINT NAME

consent to the above named clinician to provide psychotherapeutic treatment to me and/or