Telephone: (205) 933-7442 Fax: (205) 933-4012

REQUEST FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

I, _____, hereby authorize Affordable Counseling Therapy and/or designee, to release/exchange information contained in my client records to the following individual(s) and/or organization, and only under the conditions listed below:

1. Name of person(s), or organization to whom Disclosure/Exchange is to be made:

   _____

   _____

   _____

2. Specific type of information to be disclosed/exchanged: (mark which apply)

Diagnosis	Drug/Alcohol History	Text Summary
Attendance	Progress	Recommendations
Test Results	Legal Information	Follow Up

3. The purpose and need for such disclosure/exchange: (mark which apply)

Continuity of Treatment	Aftercare Planning
Family Involvement	Referral

Other: _____

_____

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date