Permission to Release and Receive Information

Your service provider is engaged in clinical supervision towards independent licensure. By signing this release of information, you are giving permission for your provider to share information from your clinical record in both verbal and written form for the purposes of clinical supervision, training and professional development. The clinical supervisor will maintain this information confidentially to the extent permissible by law and in the context of ethical obligations and responsibilities.

☐ Verbal information
_____

☐ Written information
_____

I agree that information regarding my treatment can be released to the following:

Name of Clinical Supervisor	
Address	
Phone Number	
Purpose of release	Clinical supervision

Client Name (Printed)	
Provider Name	
Agency Providing Services	

Client Signature	
Parent/Guardian Signature	
Clinician Signature	
Date	

This notice may be revoked or amended at any time in writing.