Kate Giandonato & Associates
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Release of Information (Reciprocal)		
Client Name:	**Date of Birth:**	**Client Address:**
I hereby authorize the release of the following specific information: *Please check to indicate consent for release of this information to the below provider*		
◻ Medical history, examination, laboratory tests and treatment reports ◻ Periodic reports of current treatment progress, including attendance and participation	◻ Psychological test reports ◻ Social history data including family, education, employment & other relevant material ◻ Other (please specify)	◻ Psychiatric evaluation reports ◻ Summary of previous mental health and/or counseling services ◻ Notification of referral source of initiation and termination of counseling
I hereby authorize the release of this information to be reciprocal between both Kate Giandonato & Associates and:	**Name of Agency or Individual**	**Agency or Individual's contact information**: *(Please include physical address, phone number and email address)*
◻ to develop and assess counseling and casework plan ◻ to coordinate medical, psychological and social rehabilitative process. ◻ other (please specify):		
I understand that no information may be re-disclosed by either agency to any other individual or agency unless by my written consent. This authorization may be revoked at any time by my written statement and it is automatically revoked at the end of one year from date authorization was signed or under the following specific conditions:		
This release expires on: **Signature of Client:** **Date:** **Signature of Responsible Party for Minor:** **Relationship to Minor:** **Date:** **Signature of Therapist:** **Date:**		