



**NorthPoint**  
**PROFESSIONAL COUNSELING**

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

NorthPoint Professional Counseling is hereby granted permission to

Release to  Obtain from

\_\_\_\_\_  
Name of Organization or Individual

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Daytime Telephone

\_\_\_\_\_  
Evening Telephone

Such Information As May Be Necessary Regarding the Treatment of:

Client Name(s): \_\_\_\_\_

Test Results  Treatment Recommendations  Intake Evaluation

Diagnostic Impressions  Psychosocial History  Psychiatric Evaluation

Records Summary  General Summary of Progress  Other

This "consent to disclose" may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

\_\_\_\_\_  
Signature(s) of person(s) authorizing consent

\_\_\_\_\_  
Date Signed