RELEASE OF INFORMATION

Ecumenical Center for Religion and Health
8310 Ewing Halsell
San Antonio, TX 78229
210-616-0885

Client Name: ____
DOB: _____________

I, ___________________________, hereby give the following permission to share information with the Ecumenical Center To and From:

Name of Person, Title: ____
Address: ____
Phone: ____
Fax: ____

This request is for the following purposes:

____
____
____

This request for records is limited to the following types of information:

_____ A. Testing materials and interpretations
_____ B. Clinical impressions gained in face-to-face interviews
_____ C. Progress and course of client therapy
_____ D. Consultation
_____ E. Other: ___________________________________

This request for records is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and, if not earlier revoked, it shall terminate without express revocation

____
Date, event, or condition

It is understood that this information will be kept in confidence and exchanged only for purposes stated above.

______________________________ ____
Date Client Signature

______________________________ ____
Witness Guardian Signature for Minor