DEBRA WALLACE, MS. LMFT
847.603.4677
Debra@PositiveReframe.org

RELEASE of INFORMATION FORM

_____authorizes the release, disclosure and mutual
(Name of Client or Parent/Guardian)
exchange of information between Debra Wallace MS, LMFT and the following specified person/office/organization you are granting permission to release information to (please fill in name and contact information for those that apply):

- WeCounsel.com
- Insurance_____
- EAP_____
- Other:_____

This release is regarding pertinent information concerning _____,
(Name of Client)
like payment details, history, diagnosis, medical and treatment records, psychological and educational evaluations, or the following specified information:

_____

_____

I understand that my records are protected under Federal and specific State Confidentiality laws and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by submitting a written request to Debra Wallace, and that in the event this consent expires automatically expires one year from signature date or as described below…

The date, event, or condition upon which this release expires is _____

_____

X _____
Client Signature

X _____
Client Signature

X _____
Debra Wallace MS
Marriage and Family Therapist