PASCO Counseling & Visitation
6825 Trouble Creek Rd
New Port Richey, FL 34653
(727)282-4409
pascocounseling.com

Authorization for Release of Records

Client Name_____ DOB_____

Parent/Guardian Name_____
(If Applicable)

I _____ hereby authorize Pasco Counseling & Visitation to release and receive all information pertaining to my case to the following individual.

_____ _____
(First Name) (Last Name)

_____ _____
(First Name) (Last Name)

_____ _____
(First Name) (Last Name)

I understand that this authorization will remain in effect until _____ or no longer than (1) year from the date of the signature. I understand that I may withdraw this authorization by written request at any time during this period.
(Date)

_____ _____
(Client Signature) (Witness Signature)

_____ _____
(Date) (Date)