

RELEASE OF INFORMATION

Cindy R White Counseling, PLLC

I, _____, give permission for Cindy White, LCSW, to share my information with the following agencies and individuals in regard to my case:
(Please note that your funding source has request access to billing information and progress on your case)

(Please initial all that apply)

_____ Bishop	_____
_____ Previous Therapist(s)	_____
_____ Medical Doctor(s)	_____
_____ Insurance	_____
_____ Other	_____

Additionally, I authorize the release of my records to Cindy R White Counseling, PLLC, FROM the following agencies or persons:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

_____	_____	_____	_____
Client Signature	Date	Printed Signature	Date