Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This release of information form authorizes information from my career counseling records at Essential Career Counseling to be shared with:

Name of Person or Agency:

Phone:

Street Address, City and State:

I give permission to the organization above (and its associates as needed) to share information on my career (including contents of my file and resume) for the purposes of providing additional help to the client or the need to transact payment or an administrative task as needed.

I understand that I may revoke this consent at any time. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

Signature:

Date: