

# Dr. Steve G. Conway Counselling & Psychotherapy

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## RELEASE OF INFORMATION FORM

I, \_\_\_\_\_ / \_\_\_\_\_  
(Name of Client) (Date of Birth)

### AGREE TO THE RELEASE OF THE FOLLOWING INFORMATION:

Assessment / Treatment Summaries  
 Attendance and Progress  
 Other: \_\_\_\_\_  
\_\_\_\_\_

**FOR THE PURPOSE OF** (i.e. Treatment, evaluation, assessment, etc.): \_\_\_\_\_

**I AGREE TO HAVE THIS INFORMATION RELEASED** (specify individual/company name):

From \_\_\_\_\_ To \_\_\_\_\_: DR. Steve G. Conway, RCC  
 From \_\_\_\_\_ To \_\_\_\_\_: \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_: \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_: \_\_\_\_\_

### RELEASE THE INFORMATION:

Please check all boxes that apply and are deemed acceptable communication methods.

By Phone (consults only – not for written purposes)  By E-Mail (I understand that confidentiality **cannot**  
be guaranteed if this form of communication is used)  By Fax  By Mail

\_\_\_\_\_ DATE (MM/DD/YYYY)  
\_\_\_\_\_ CLIENT SIGNATURE

**This consent is valid for 90 days from the date of signature. The client may cancel it at any time with verbal or written notice to Dr. Steve G. Conway, RCC.**