Client Name _____ Date _____

I authorize Donna VanderKodde LPC to (check one or both) to:
___ release
___ obtain information and records to/from the person/agency identified below:

Name/Agency: _____
Address: _____
Phone: _____ Fax: _____

Records Authorized to be Release/Obtained:
_____ Medical/Health Records
_____ Psychological Reports/Progress Notes
_____ School Records
_____ Other: _____

This information will be used for the purpose of:
_____ Coordination of Care
_____ Other: _____

Please initial each statement below to indicate that you have read and understand each.
_____ This authorization will expire one year from the date of the signature below.
_____ I understand that I can revoke this authorization at any time.
_____ I understand that I am entitled to receive a copy of this authorization.
_____ A copy of this authorization may be utilized with the same effectiveness as the original.

Client/Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

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