



Abby Napora Individual & Couples Counselling

BCACC Registration # 11642

Release of Information

Client's name: _____

First Name Middle Name Last Name

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:

Name (client, or other - parent/guardian)

5. Information to be released:

Authorization for Clinical Notes ONLY

Other (describe information in detail):

6. Purpose of Disclosure: The reason I am authorizing release is:

- My request
- Other (describe):

7. Person(s) Authorized to Make the Disclosure:

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8. Person(s) Authorized to Receive the Disclosure:

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:

Authorization and Signature: I authorize the release of my confidential and protected counselling information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.

Signature of the client: _____
(Other - Parent/Guardian)

Signature of Clinical Counsellor: _____

Date of signature: _____



A designation of BC Association of Clinical Counsellors