



Reciprocal Release of Information

Today's Date: _____

I understand that Begin Within Therapy Services generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. However, failure to sign this authorization may have the following consequences:

I understand that I have the **right to inspect** and receive a copy of the information to be disclosed. I may request a copy of this authorization for my records.

Signature of Client if 12 and over Date

Signature of Parent, Guardian, or Personal Representative Date

Signature of Parent, Guardian, or Personal Representative Date
(If you are signing as a personal representative, describe your authority to act for this individual; power of attorney, etc.)

_____ Check here if client refuses to sign authorization.

Signature of Witness Date