



**AUTHORIZATION FOR THE RELEASE OF  
CONFIDENTIAL INFORMATION**

Jeffrey J. Crum – Pastoral Counselor

1. **Clients name:** \_\_\_\_\_  
First Name Middle Name Last Name

2. **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

3. **Date authorization initiated:** \_\_\_\_/\_\_\_\_/\_\_\_\_

4. **Authorization initiated by:** Name (client, provider or other) \_\_\_\_\_

5. **Information to be Released:**  Authorization to release Counseling File

◆ **Other** (describe information in detail): \_\_\_\_\_

6. **Purpose of Disclosure:** I am authorizing release for the purpose of consultation and/or testimonial edification

7. **Person(s) Authorized to Make the Disclosure:** Jeffrey J. Crum. 2514 E. Pacific Ave. Spokane, WA 99202, 509-475-5378

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

A. Mark Sandford  B. Ministry staff  C. Testimony Publication  Other: \_\_\_\_\_  A, B, & C

9. **My name may be used in the following form:**  Full name  First name only  I would rather remain anonymous

10. **Limit of Authorization:** I can cancel this authorization with a dated letter of revocation including signature.

**I hereby authorize the release of my confidential protected counseling information, as described in my directions above. I understand that this authorization is voluntary.**

**Signature of the client:** X \_\_\_\_\_

**Signature of Personal Representative for a Minor:** X \_\_\_\_\_

**Relationship to Client if Personal Representative:** \_\_\_\_\_

**Date of signature:** \_\_\_\_/\_\_\_\_/\_\_\_\_