

Dana Hunt Unruh, MS LCPC  
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RELEASE OF INFORMATION

Re: \_\_\_\_\_ Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize the mutual exchange of confidential information between Dana Hunt Unruh, MS, LCPC and the following agency, practitioner, school or individual.

Agency/Practitioner/School: \_\_\_\_\_  
Individual \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

Information requested: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Purpose or Need for this disclosure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The specific nature of the information and its benefits and disadvantages have been fully explained to me. I have been informed that any treatment, assessment or evaluation will not be impacted by my decision concerning this release. I also understand that this release may be revoked at any time and unless otherwise stated shall terminate after two years from the date below. By signing this release, I release this agency, counselor, and/or organization from any liability arising from the release of this information to such designated persons, agencies, or school.

\_\_\_\_\_  
Signature of counselor: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of parent, guardian, or client representative