

**Balanced Choices**  
**John F Cattich, LMFT**  
**126 South Main Street, Suite 2B**  
**Davidson, NC 28036**  
**Phone: 704-655-2827**

Client's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_

I consent to the release and exchange of all information between John Cattich and the following persons and/or agencies:

Person(s) \_\_\_\_\_ Agency \_\_\_\_\_

Person(s) \_\_\_\_\_ Agency \_\_\_\_\_

Person(s) \_\_\_\_\_ Agency \_\_\_\_\_

Person(s) \_\_\_\_\_ Agency \_\_\_\_\_

This information includes psychiatric/psychological and medical information including alcohol and drug abuse or addition data from my health records.

All information released to John Cattich will be used solely for assessment of, and planning for, client's needs and for developing a counseling plan to meet those needs.

This consent for release and exchange of information is valid until treatment is discontinued.

I understand that I have the right to refuse to sign this authorization and that John Cattich is released from all legal liability that may arise from the release of the information requested. I understand that I may revoke this release, in writing, at any time, except to the extent that it has already been acted upon.

A fax or photocopy of this release is to be considered as valid as the original.

\_\_\_\_\_  
Parent/Legal Guardian or Printed Name Date  
Client Signature

\_\_\_\_\_  
Therapist Signature Date