Chagrin Counseling Associates
& Eating Recovery

AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Client Name: ____

DOB: ____

Information to be released to or exchanged with:

Name: _________________________ Position: ________________

Address: ____

Phone: ____

Client Signature: ____

Date: ____

Therapist Signature: _____________________________________

Date: ____

Supervisor Signature: ____________________________________

Date: ____