Sandra R. Champe, Ph.D.

CLIENT MEDICAL RELEASE AUTHORIZATION

If you would like me to send information to your referring physician, any other medical professionals, or entity, please indicate below.

I, _____

authorize Sandra R Champe, Ph.D. to release information contained in my records to, or receive information contained in my records from, the individuals or organization listed below:

1. **Name of person(s) or organization(s) to whom disclosure is to be made:**

2. **Specific type of information to be disclosed:**

   Evaluation, treatment planning, progress information and discharge summary

3. **Purpose for disclosure:**

   Coordination of care

_____ _____

Client's Signature **Date**

West Maple Family Counseling
5600 West Maple Road, Ste. D-410
West Bloomfield, MI 48322
(248) 339 6618