

**Ashley Miller, LCSW**

Valley Wellness Counseling  
20 Woodside Avenue  
Middlebury, CT 06762

**Authorization to Release Information**

I, \_\_\_\_\_, (client and/or legal guardian), give permission to Ashley

Miller, LCSW to receive and release to:

\_\_\_\_\_  
(Name/Agency)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone Number)

The following information (check all that apply):

- Attendance in therapy
- Diagnosis and diagnostic impressions
- Treatment plan goals and progress
- Information/Documentation relevant to coordinating care
- Discharge date and reasons
- other (please explain in detail) \_\_\_\_\_

I understand that this release is valid for a period of one year. I further understand that I may revoke this authorization at any time in writing.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

\_\_\_\_\_  
Client/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Ashley Miller, LCSW

\_\_\_\_\_  
Date

ValleyWellnessCounseling