DR. ANDREW GRAHAM
PROFESSIONAL COUNSELING FROM A CHRISTIAN PERSPECTIVE

Release of Information

Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone:_____Email: _____

I authorize Dr. Andrew Graham to:

☐ Release Information to ☐ Obtain Information to

Name/Organization: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone:_____Email: _____

I authorize information to be released by the following methods:

☐ Phone ☐ Email ☐ Mail ☐ Other

My signature below indicates that I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain counseling and that I may revoke this authorization at any time by submitting a written request to Dr. Andrew Graham. I certify that this form has been fully explained to me and I understand its contents.

_____ _____

Client Signature Date Witness Signature Date