

Aspire Counseling Services
1050 Connecticut Ave N.W.
Suite 500
Washington, D.C. 20036
(202) 527.9120 Office



READ FIRST: Before you decide whether or not to let Aspire Counseling Services share some of your confidential information with another agency or person, an advocate at Aspire Counseling Services will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want Aspire Counseling Services to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that Aspire Counseling Services has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Aspire Counseling Services to release some of my personal information to certain individuals or agencies.

I, _____, authorize Aspire Counseling Services to share the following specific information with:

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:
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The information may be shared: in person by phone by fax by mail by e-mail
 I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What info about me will be shared:	
Why I want my info shared: (purpose)	

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by Aspire Counseling Services.

I understand:

- That I do not have to sign a release form. I do not have to allow Aspire Counseling Services to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like Aspire Counseling Services to release information about me in the future, I will need to sign another written, time-limited release.
- That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Aspire Counseling Services.
- That Aspire Counseling Services and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

This release expires on _____
Date _____ Time _____

Expiration should meet the needs of the client, which is typically no more than 15-30 days, but may be shorter or longer.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Date: _____

Signed: _____ Time: _____ Witness: _____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until _____
New Date _____ New Time _____

Signed: _____ Date: _____ Witness: _____