OLIVE BRANCH
COUNSELING

# Referral and Release of Information Form

## Client Information

Full Name: _____

Date of Birth: _____ / _____ / _____

Parent/Guardian Name (if minor): _____

Phone Number: _____

Email Address: _____

Preferred Contact Method: ☐ Phone ☐ Email

## Referral Information

Referred By (Organization/Practitioner Name): _____

Phone: _____ Email: _____

Reason for Referral / Presenting Concerns:

_____

_____

Is there a preferred therapist or specialty?

☐ No ☐ Yes: _____

## Insurance / Payment Info

Payment Type: ☐ Private Pay ☐ Insurance (specify): _____

## Release of Information Authorization

I authorize Olive Branch Counseling to contact me (the client/guardian) and the referring provider listed above to coordinate care. This release remains valid for one year unless revoked in writing.

Client/Guardian Signature: _____

Date: _____ / _____ / _____

*Please fax the completed form to (469) 409-0544 or email it to info@olivebranchdfw.com.*
*A member of our team will reach out to the client within 24 business hours of receiving the referral.*