Maple Counseling Center----------

Client Name:	**Date:**
Primary Doctor:	Release Signed**:**
Medications**:**	
	Please add on back if there are more
Other Information**:**	
Action Items**:** (for office use)	Date:

Psychiatrist:	Release Signed:
Medications**:**	
	Please add on back if there are more
Other information**:**	
Action Items: (for office use)	Date:

Probation officer, Social Worker, Attorney, any other party involved: Name and contact information	Release signed?
Action Items: (for office use)	Date: