

**Authorization for Release of Confidential Information**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize, Therapist, Dianna Westbrook,

Responsible Party Name

LPC, MHSP to **Release, Request, Share** (circle all that apply) confidential medical record information **To,**

**From, With** (circle all that apply), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Provider/Therapist Phone

Information shall consist of: Duplicate records and/or consultation concerning treatment and/or education.

Specifically: ⃝ All Clinical Records ⃝ Educational Records

⃝ Mental Health Records ⃝ Drug/Alcohol Records

⃝ Relationship Counseling Records

⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information is needed for the purpose of adopting a more comprehensive and integrated approach to services and maintaining a continuity of care for this purpose only unless otherwise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoke, it shall terminate the last day of the clinical treatment.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. I have read and understand the nature of this release. I understand that I may revoke it at any time. I release Dianna Westbrook, LPC, MHSP from any liability that may arise from this action whether or not foreseen at present. I understand that certain medical records may be protected by Federal Regulations.

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Signature of client Date

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Signature of client Date

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Dianna Westbrook, LPC, MHSP Date