



Life Matters Counseling, PLLC

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Authorization to Release/Exchange Confidential Information

Name of Client: _____ Date of birth: _____

I understand that the purpose of this release is to assist with my/this patient’s treatment by improving communication between: _____, and other professionals whom I have named below (such as but not limited to physicians, inpatient treatment providers, etc.), or other individuals (such as family members, pastors, etc.). To further this goal, I authorize this specific therapist to release the below-specified information regarding me/the client to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below:

- Complete Treatment Record** Treatment summary Treatment plan Progress notes
- Compliance with treatment Psychological evaluation Medications Diagnosis
- Scheduled appointments Finances / Billing Other: _____

This information is to be released/exchanged with these persons:

<i>Name of person for the release/exchange of information</i>	<i>Relationship to the Client</i>
<i>Phone Number(s)</i>	<i>Address</i>

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire one year from this date, upon my discharge from treatment by this agency or by the person specified above, or under these circumstances: _____

<i>Signature of Client</i>	<i>Printed Name</i>	<i>Date</i>

<i>Signature of Parent/Guardian/Representative</i>	<i>Printed Name</i>	<i>Relationship</i>	<i>Date</i>

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

<i>Signature of Witness</i>	<i>Printed Name</i>	<i>Date</i>