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, and any items not to be released have a line drawn through them:

❑ **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 disclosed to these persons, who have the indicated relationship to me/the patient:

_____ _____

Name of Person *Relationship to the Client*

_____ _____

Phone Number(s) *Address*

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: _____

_____

_____ _____ _____

Signature of Client *Printed Name* *Date*

_____ _____ _____ _____

Signature of Parent/Guardian/Representative *Printed Name* *Relationship* *Date*

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.

_____ _____ _____

Signature of Witness *Printed Name* *Date*