

Authorization for Release of Information

Client's Name: _____

Record No. _____

This will authorize Anna D. Skinner, LPC to release information to:

_____ Initial here if the above named party(ies) have authorization to disclose information to Anna D. Skinner, LPC.

Written and/or verbal information pertaining to the following may be released:

- Psychiatric Evaluation Medication Records
- Treatment Plan / Summary Progress Reports
- Psychological Reports / Testing
- Educational Reports / Testing
- Other: _____

The information hereby released will be used for the following purpose(s):

- Evaluation Treatment Planning Other: _____

I understand that additional consent must be obtained for any other transfer or disclosure of information.

This authorization shall become effective ____/____/____. Expiration date should not exceed 90 days from effective date unless treatment planning justifies ongoing communication with the above-named party / agency. Under no circumstances should expiration date exceed one year.

I understand that I have a right to receive a copy of this authorization if I so request.

Signature of Client/Guardian

Date

Printed Name of Guardian

A photocopy of this form is as valid as original document