Laurie Kimmel, LMSW, ACSW, PLLC
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Authorization To Release Information

I _____ hereby authorize Laurie Kimmel, LMSW, to disclose mental health treatment information obtained in my patient records, including, but not limited to, her diagnosis of me, to the individuals or organizations listed below, only under the conditions listed below:

Birthdate of Patient_____ Social Security Number xxx-xx-_____

1. Names of individual(s) or organization(s) to/from whom disclosure is to be made:
   _____
   _____

2. Specific type of information disclosed:_____
_____

3. The form in which the information may be disclosed is (Check one or more options):

verbal communication_____ written report or photocopies of records _____ or other (explain) _____

4. The purpose and need for such disclosure: (Include a statement as to how the information to be disclosed is pertinent to the purpose and need for such disclosure.)
_____
_____

5. This consent is subject to revocation at any time except in those circumstances in which L. Kimmel.LMSW has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished.

6. Without expressed revocation, this consent expires for the following specific reasons:
   Date _____ Event _____ Termination of therapy _____

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Michigan law may protect such information.

Patient's signature: _____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____