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Release of Confidential Information

Name _____ Date of Birth _____

I grant Amy E. Brown, MS, CAC, LPC explicit permission to release my protected health information (PHI) to-or obtain my PHI from-

_____
(This permission includes telephone contact as needed for consultation, evaluation, and treatment)

Purpose(s) of information release: (check all that apply):
□ Coordination of care □ School Contact □ Legal matters
□Other (specify) _____

Specific information to be released (check all that apply):
□ Presence in treatment □ Evaluation results and recommendations
□ Treatment attendance □ Treatment participation and progress
□ Results of lab tests □ other (specify) _____

□Exclusions: _____

This release of information Includes: Psychiatric/Psychological, Educational, Drug/Alcohol/Substance Abuse, AIDS/HIV ,Social Work, Medical, and Legal records and information unless specifically excluded.
This release will expire on _____unless otherwise revoked.

Client name (print) _____

Client signature _____ Date_____

(If client is under 14 years of age)
Printed name and signature of parent/guardian

Name: _____ Relationship to client _____

Signature _____ Date _____

Witness_____ Date _____