PAHRUMP VALLEY COUNSELING

3370 S. Highway 160, Suite 12
Pahrump, NV 89048
Office (775) 751-8980
Fax (775) 751-8650

**Request for Information and/or**
**Authorization for Release of Confidential Information**

**Information Requested From:**
l. Ramona Sanchez, LCSW, LMFT →
2. →

**Information Released To:**
1.
2. Ramona Sanchez, LCSW, LMFT

I hereby authorize and/or consent to the disclosure of the information checked and initialed below from the records of:

**Name:**_____ **Date of Birth:**_____

***(Each item of information to be released must be initialed)***

| | | |
|---|---|---|
| ☐ Discharge Summary____ | ☐ Medication Records ____ | ☐ Psychotherapy/Case Management Notes___ |
| ☐ History & Physical Exams ____ | ☐ Physician's Orders ____ | ☐ Nursing Notes ____ |
| ☐ Psychiatric Evaluation ____ | ☐ Diagnosis ____ | ☐ Consultation reports ____ |
| ☐ Treatment Plans ____ | ☐ Intake Evaluation ____ | ☐ Lab/X-ray ____ |

☐ Other (specify): _____

For the purpose of: _____

_____

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. I may revoke this release in writing at any time and without penalty or denial of services. This authorization expires _____.

It is understood that the policy of the Pahrump Valley Counseling Service is to release only that information about a client or a former client, which, in the judgment of the staff, is considered essential to the purposes for which authorization is requested. This in no way binds Pahrump Valley Counseling Service to open its records for inspection, or to otherwise provide information which may violate the above policy. Medical Records are protected by Federal Regulations, Nevada Statutes and/or Administrative Regulations and any further disclosure is prohibited without the consent of the undersigned. Pahrump Valley Counseling Services cannot guarantee that further disclosure will not occur.

A. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefit or enrollment, payment for or coverage of services, or ability to obtain treatment.
B. I understand that I may inspect or copy the information used or disclosed.
C. I understand that I may revoke this authorization at any time by notifying Pahrump Valley Counseling Service in writing, except to the extent that:
   1. Action has been taken in reliance on this authorization; or
   2. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
D. I understand that I have a right to request and receive a Notice of Privacy Practices from Pahrump Valley Counseling Service.
E. I understand that in cases of suspected or known child mal-treatment that the providers of Pahrump Valley Counseling Service are mandated reporters under Federal and State law and are legally responsible for reporting such information to Child Protective Services.

I further release my clinician, the agency and the employees of the agency from any liability arising from the release of information to the person/agency designated above.

_____ _____
Date Signature – Client

_____ _____
Date Signature ☐ Parent ☐ Guardian ☐ Custodian

_____ _____
Date Signature of Witness

**Please complete & sign this form if information needs to be obtained or released.**