Susan Strong

MED in Counseling
Licensed Professional Counselor
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(928) 445-0055

Release of Information

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____ SSN: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Message Phone: _____

I, _____, hereby authorize Susan Strong, MED, LPC, NCC, to release and exchange my psychiatric and/or mental health information to:

Person/Agency: _____ Relationship: _____

Address: _____ Phone: _____ Fax: _____

For the purpose of: ☐ continuity of care ☐ other: _____

I understand that my protected health information may be used and disclosed to carry out treatment, for payment of services, or for health care operations to improve the quality of care.

I acknowledge receipt of the Notice of Privacy and Practices and I understand that I have the right to review the Notice before signing this consent. I understand that any changes in the Notice are available upon request.

I understand that this authorization is in effect for one calendar year from the date on this form.

I understand that the exchange of information may include history and/or current struggle with addiction and/or substances. I agree this information can be disclosed. Initials: ☐

I understand that I have the right to revoke in writing this authorization to release my protected health information.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Legal Representative Name	Legal Representative Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date