Audra York Therapy, LLC
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Request/Authorization to Release Confidential Records and Information

Release From: _____ Phone Number:_____

Address:_____

Release To: _____ Phone Number:_____

Address:_____

Client Name:_____ DOB: _____

Address:_____ SSN: _____

Information To Be Released:

Type of Communication

❑Verbal ❑Written

Information to be Released:

❑ Intake and Discharge Summaries ❑ Mental Health Assessments ❑ Treatment Plans

❑ Progress Notes ❑ Other: _____

For the Following Purpose(s):

❑ Personal (at request of client) ❑ Treatment ❑ Legal ❑ Other: _____

I understand this request/authorization to release records and information is voluntary. I understand the nature of this request, the records, their contents, and the likely consequences and implications of their release. I understand that I may revoke this voluntary consent at any time before the end date.

Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing. Unless revoked earlier, this authorization will expire one year from the date on which it was signed, or upon the following **date or event**:_____

I understand that once the above information is disclosed, it may be subject to re-disclosure by the receipt and no longer protected by federal privacy laws or regulations.

_____ _____ _____

Signature of client or guardian Printed name Date

_____ _____ _____

Signature of client or guardian Printed name Date