Audra York, MS, LPC-S, RPT-S
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Request/Authorization to Release & Receive Confidential Records and Information

Client Name (legal):____DOB:_____________________

Address:____

Phone Number:______________________________________

I, ____in relation,________________________, to client
(self, parent, legal guardian)

authorize Ms. York to release and receive information from:

Agency/Persons exchanging records & information: ____

Specific Office/Persons at Agency: _______________________Phone Number:_____________________

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 & receive records and information is voluntary and I do not have to sign this form. 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 3 months 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.

Signed:____ Date:______________________

Printed Name:____

Signed:____ Date:______________________

Printed Name:____

Witness:_____________________________

Updated 11/2019