KATHRINE ANDERSON
COUNSELING
MENTAL AND BEHAVIORAL HEALTH SERVICES

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Request/Authorization for Release of Information

I, _____, hereby authorize Kathrine Anderson, MA, LPC, NCC, to release and/or request the following information concerning me to and/or from:

Name of person/hospital/agency/company/school:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

1. The disclosure of information and records is required for the following purpose:

- ❑ Continuity of treatment
- ❑ Legal provision
- ❑ Medical
- ❑ Billing
- ❑ Psychiatric
- ❑ Family involvement
- ❑ Other:_____

2. The specific type(s) of information to be disclosed are as follows:

- ❑ All records
- ❑ Psychological evaluation/testing
- ❑ Presence in treatment
- ❑ Verbal and/or written progress
- ❑ Admission and discharge summaries
- ❑ Treatment plan
- ❑ Other: _____

Without expressed revocation, this consent is valid until 1 year from now or at the conclusion of treatment, whichever comes first. I certify that this request has been made voluntarily. I understand that this information may not be released to or received from any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid. The information disclosed and/or requested shall not be used for any purpose other than its intended use. I understand that I have the right to revoke this release. I understand that once the information is disclosed, it may no longer be protected. I hereby release Kathrine Anderson, MA, LPC, NCC from liability that may result from furnishing this information.

_____ _____

Signature of Client or Responsible Party Date

_____ _____

Signature of Witness Date