Lifepointe Counseling and Consulting Services

Kristel Headley, Ph.D., LPC-MHSP, ACS

AUTHORIZATION TO RELEASE INFORMATION

I authorize Lifepointe Counseling and Consulting Services to release to, and receive from:

Name ____Phone: ____________________

Address ____

[ ] School System [ ] Hospital [ ] Private
[ ] Pediatrician [ ] Court System [ ] Other
[ ] Family Member/Support person

The following information on ____ ______________
(Patient Name) (DOB)

_____Medical Records
_____Medical History/Physical
_____Psychological Evaluation
_____Social History
_____Neurological Evaluation
_____Academic Records/Educational Evaluation
_____Treatment Plan/Patient Progress
_____Discharge Summary
_____Special Education File
_____Results of Drug/Alcohol Treatment/Testing

Other (Specify): ____

For the purpose of: ____

Referral question (if applicable): ____

____

Approximate dates of service: ____

Name of Counselor:_______________________________________Cell Phone: ___________________

I have been informed of the type of information being released, the benefits and disadvantages (if any), and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Signature of Patient: ____ Date: ___________

Signature of Custodial Parent/Guardian: ______________________________ Date: ______________
(If patient is a minor)

Signature of Witness: ____ Date: ____________________

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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