LOOK INSIDE COUNSELING

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Release of Information Authorization

I, _____, whose Date of Birth is _____, authorize any employee of Look Inside Counseling, PC to disclose to and/or obtain from: *(name or organization info is being released to/received from)* _____ the following information:

_____

Purpose *(please circle)*:

Coordination of Treatment Services | Clinical Notes | Clinical Impression of Client |
Other: _____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by providing a written notice of revocation to Look Inside Counseling, PC. I further understand that a revocation of this authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this consent expires on the following date: _____ If a calendar date is not stated, information may only be released on the date the authorization is received.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure: State and Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the personal to whom it pertain or as otherwise permitted.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

_____ _____
Patient/Client Signature Date

_____ _____
Parent/Legal Guardian/Personal Representative Signature Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, health care surrogate, etc.). *(Fill in Purpose)*

_____ _____
Therapist Signature Date