Shelly Thompson, M.Ed., LPC-S
Licensed Professional Counselor
Phone 806-798-3000 Fax 806-798-3000

Authority to Release/Receive Information

Name: _____ Date: _____

I (We) authorize Shelly Thompson to:

____ **release** ____ **receive** ____ **exchange** information regarding above named client.

____ **to:** ____ **from:** ____ **with:** _____

_____

Information to be Released and/or Received:

____ Admission notes
____ Progress notes
____ Records request
____ Other information as specified: _____
_____

____ Diagnosis/Assessment results
____ Separation summary
____ Consultation

Purpose of this Release:

____ Status treatment progress
____ Mental health evaluation
____ Medical treatment
____ Other reason(s) as specified: _____
_____

____Provide treatment summary
____ Social history
____ Psychiatric evaluation

_____ _____
client signature signature of person securing release of information

_____
address

_____

_____
phone

To the party/parties receiving information at the request of the named person: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (52 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other is not sufficient for this purpose.

This consent for release of information will be voided at the request of the client or guardian.