Request/Authorization to Release Confidential Records and Information

I, (Name)_____ hereby authorize **Jennifer B. Locklear at Lewisville Family Counseling, PLLC, PO Box 267, Lewisville, NC 27023 Phone: 336-945-0137, Fax: 336-946-9084** to __release __exchange __re-disclose the records and information listed below concerning the client _____ whose date of birth is _____ to the following person or facility: _____
Person/Facility Address:
_____
_____
Phone: _____ Fax: _____

The purpose of this release of information is as follows:

☐ Further mental health evaluation, treatment, or care ☐ Rehabilitation program development or services
☐ Treatment planning ☐ Care Coordination ☐ Other: _____

In the boxes below, the information to be disclosed is marked by an X, the items not to be released have a line drawn through them and, page numbers are indicated when appropriate. Any written dates indicate when those records were mailed to the requester.

☐ Intake and discharge summaries _____ ☐ Medical history and evaluation(s) _____
☐ Mental health evaluations _____ ☐ Developmental and/or social history_____
☐ Educational records _____ ☐ Progress notes, and treatment or closing summary _____
☐ Other: _____
_____
_____

HIV-related information and drug and alcohol information contained in these records will not be released under this consent unless indicated here: ☐Do release HIV-related information ☐ Do release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within one year, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____
Signature of client Date

_____
Printed name of client

_____ _____
Signature of client's personal representative (if appropriate) Date

_____
Printed name of client's personal representative

_____
Description of personal representative's authority

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature (if applicable).

_____ _____ _____
Signature of witness Printed name Date

_____ _____
Jennifer B. Locklear, MS/EdS, NCC, LCMHC, LCMHCS, CCS Effective Date of Authorization