Lewisville Family Counseling PLLC

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Request/Authorization to Release Confidential Records and Information

This form will allow the counselors and/or staff of Lewisville Family Counseling, PLLC to send records or communicate with other people.

Client Name (printed) _____ Date of Birth _____

I (the above named client) give Sarah MacReynolds at Lewisville Family Counseling, PLLC (PO Box 267, Lewisville, NC 27023; phone 336-945-0137; fax 336-946-9084) authorization to:

_____ Release Records *(share our records with another person, provider, or facility)*

_____ Exchange Records *(share our records and receive records from another person, provider, or facility)*

Person, provider, or facility: _____

City: _____State: _____ Fax #: _____ Phone #: _____

The following information may be released (check as many as apply): _____ All records

____ Medical Records ____ Diagnostic & Lab Tests ____ Counseling Assessment & Progress Notes

____ Psychiatric Records ____ Psychological Testing ____ Records of Psychiatric Hospitalization

____ Conversation ____ Substance Use Treatment ____ Other _____

Regarding services rendered during the following dates:

____ Check here for all dates OR List a specific range of dates: _____

The purpose of this disclosure is: ____ Treatment ____ Legal Purposes ____ Disability ____ Family Involvement

Other: _____

This authorization will expire on _____ ***(Note: If blank, it expires 12 months for the date signed. If you do not want it to expire, please choose an expiration date far in the future.)***

I understand that I may revoke this authorization at any time, except to the extent that action based on this consent has already been taken. However, I must revoke authorization in writing and present the written revocation to Lewisville Family Counseling. In addition, a revocation will not apply to my insurance company when the insurance company has a legal right to contest a claim.

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. I understand that if my records include information relating to HIV infection, alcohol use, drug use, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information. This request is entirely voluntary on my part and will not affect my ability to obtain services. I understand that I may request a copy of this signed authorization.

_____ _____
Signature of client Date

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

_____ _____
Printed name of client's personal representative Description of personal representative's authority