PENNY MANNING LCPC

Request/Authorization for Release of Information

Client Name _____ Date of Birth _____

Hereby authorize Penny Manning to release information contained in my client records to the following individual(s) and/or organization(s), and only under the conditions below:

1. Name and address of person(s), organization(s) to whom disclosure is to be made: _____

_____

_____

Approximate dates of service from which information is requested: _____

2. Information to be disclosed:

- ☐ Diagnosis
- ☐ Drug/Alcohol History
- ☐ Treatment Summary
- ☐ Attendance
- ☐ Mental Status Exam
- ☐ Entire Record
- ☐ Progress
- ☐ Physical Examination
- ☐ Other
- ☐ Prognosis
- ☐ Discharge Summary

3. Purpose of disclosure:

- ☐ Provision of Mental Health Services
- ☐ Billing Purposes
- ☐ Aftercare Planning
- ☐ Continuity of Treatment
- ☐ Family Involvement
- ☐ P.O./Attorney/Judge/ Court
- ☐ Other

4. This release will expire on: _____

5. STATE ANY EXCEPTIONS: _____

_____

_____

I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to Penny Manning except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the person named above will not release my health information. The above named person will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. If I refuse to release information, it may negatively impact my quality of care in that providers will not be able to coordinate care between each other, which may limit my recovery. RE-DISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that the health information disclosed under this Authorization might not be re-disclosed by the recipient to others without the written consent of this client. Federal law, rules, and regulations prohibit the recipient from further disclosing any health information that may be included regarding diagnosis or treatment for Mental Illness, HIV, or drug/alcohol abuse.

_____ _____

Client (Parent/Guardian) Signature Date

_____ _____

Therapist Signature Date