SJCardwell
COUNSELING & CONSULTING PLLC
Journey Vision Growth

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION
(Use Black Ink Only)

Client Name: _____ Phone#: _____ SS#: _____ DOB: _____

I Hereby Authorize:
Name: Susan J Cardwell, M.A., LPC-S
Address: 4245 Kemp Blvd, Suite 315
City: Wichita Falls State: TX Zip: 76308
Contact Person: Susan Cardwell Phone: 940-691-1267

☐ **To Release to:**
☐ **To Obtain From:**
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____ Phone: _____

Information to be Released: (check all that apply):

- ☐ Client ID (Phone, Address)
- ☐ Assessment/Social History
- ☐ Treatment Plan
- ☐ Verbal Exchange
- ☐ Other: _____
- ☐ Diagnosis
- ☐ Psychological Evaluation
- ☐ Progress Notes
- ☐ Discharge Summary

This release is for the following reason(s) (be specific): _____

_____

NOTE: The above information may include drug and alcohol/mental health/communicable disease information, including HIV test results, AIDS related information. I have been informed that this specific release is required because if my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records; 42 CFR, Part 2, the records cannot be disclosed without my written consent unless otherwise provided for in the regulations. A general authorization for the release of medical or other information is **not** sufficient for this purpose. If I am signing as a parent of a minor child or guardian of a minor child, I further understand the information released may contain references to my family or myself. Except for the information related to alcohol or drug abuse treatment, the information disclosed pursuant to this authorization may not be protected by medical privacy laws and may be subject to re-disclosure by the recipient. The authorizing person through written notice may revoke this authorization at any time, except to the extent that Cardwell Counseling has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices. We will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign the authorization. If not earlier revoked, this consent shall expire on:

_____ or Not **to exceed One (1) year from date of client signature.**
Date or event

This authorization is hereby revoked at my request:

Form must be completed before signing

Client Signature	Date	Client Signature	Date
Legal Authorized Representative And Relationship to Client	Date	Legal Authorized Representative	Date
Witness	Date	Witness	Date

_____ Action by Medical Records
_____ File in Chart