

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

(Use Black Ink Only)

Client Name: Phone#: SS#: DOB:

**I Hereby** Name: Susan J Cardwell, M.A., LPC-S

**Authorize**: Address 4245 Kemp Blvd, Suite 315

 City: Wichita Falls State: TX Zip: 76308

 Contact Person: Susan Cardwell Phone: 940-691-1267

 **To Release to: Name:**

 **To Obtain From:**

 Address:

 City: State: Zip:

 Contact Person: Phone:

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

Client ID (Phone, Address) Diagnosis

 Assessment/Social History Psychological Evaluation

 Treatment Plan Progress Notes

 Verbal Exchange Discharge Summary

 Other:

**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 Date Legal Authorized Representative Date

And Relationship to Client

Witness Date Witness Date

 Action by Medical Records

 File in Chart Updated 07/06/17