Authorization to Release Mental Health Information

I, _____, DOB_____,
authorize Survive and Thrive Counseling, LLC and Andrea Maren Whipple to _____release information to; _____exchange information with:

Name/Organization_____

Address_____

Phone Number_____ Fax_____

Specific nature of information to be released:

_____ any or all of the following:
_____ attendance/scheduling/transportation
_____ information related to payment
_____ presenting complaint/issues
_____ diagnosis and/or assessment results
_____ treatment plan and goals
_____ summary of treatment
_____ response to treatment
_____ prognosis
_____ recommendations/suggestions
_____substance use information ____(initials)
_____ other _____

The information above is being released for the purpose of:

_____ facilitating consultation and/or collaboration
_____ facilitating continuity of treatment
_____ facilitating scheduling/transportation
_____ facilitating payment
_____ facilitating involvement of support person(s) in treatment
_____ other _____

I understand that:

1. This consent with automatically expire one year from date of signing unless a different date is indicated here_____.
2. I have the right to inspect the information being disclosed.
3. I have the right to revoke this authorization, in writing, at any time by sending such notification to my provider's office. However, my revocation will not be effective to the extent that my provider has already taken action in reliance on this authorization.

Client (adult or minor over age 12) Date

Parent/Guardian (if applicable) Date

Witness Date