YOUR JOURNEY COUNSELING SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Date of Birth: _____
Guardian Name: _____
Address:_____
_____

Release to: Marlene R. Ewert, LCMFT, RPT-S, CTS-C
414 N. Main Street, Suite 220
Newton, KS 67114
316-804-7240
marlene@yourjourneycounseling.com

Purpose of Disclosure:
__to coordinate treatment
__at the request of the patient
__other _____

This authorization is to ___Exchange information with:
___Disclose information to:
___Obtain information from:

_____
_____
_____
Phone/Fax _____

Check information to be disclosed/exchanged:
_____Outpatient Admission

_____SED determination

_____Psych testing

_____Treatment plan

_____Medication evaluation and med check notes

_____Therapy notes/Progress notes

_____School records

_____Entire record

This release includes email communication._____

Expiration Date: _____

_____
Printed Name of Patient

_____
Printed Name of Representative

_____
Signature of Patient

_____
Signature of Representative

_____
Date and Time

_____
Description of Representative's Authority

_____
Your Journey Representative

_____
Address

_____
Date and Time

_____ _____
Phone Date and Time