James P. Kelleher, MA, NCC, LPC

602.321.9536

Request/Authorization to Release Confidential Records and Information

I _____hereby authorize:

Person or facility:

_____

_____

Address:

_____

_____

Phone: _____

to release information from records about _____, born on _____ , and whose Social Security number is _____, for the following purpose(s):

- ☐ Further mental health evaluation, treatment, or care

These records concern the time between _____ and _____.

In the boxes below, the information to be disclosed is marked by an X, the items not to be released have a line drawn through them and, page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

- ☐ Intake and discharge summaries
- ☐ Mental health evaluations
- ☐ Progress notes
- ☐ Medical history and evaluation(s)
- ☐ Developmental and/or social history
- ☐ Treatment plans, recovery plans, aftercare plans.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____ _____

Signature of Client | Printed name | Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ _____ _____

Signature of Witness | Printed name | Date