Tara Yardley LPC LLC

Authorization for release of information

I (We) authorize Tara Yardley, LPC LLC and/or Yardley Counseling LLC to release
(Facility/Provider)

Counseling Medical records from the clinical record of _____

(Name of client/recipient of mental health services)

Date of birth:_____

To/From _____, _____
(Name of facility or agent needing or disclosing information) (Address, Email or phone number of other agency)

For the purpose of facilitating counseling/consultation, and/or conducting an evaluation.

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Tara Yardley LPC LLC. I understand that a revocation is not valid to the extent that Tara Yardley LPC LLC has acted in reliance on such authorization. This authorization is valid until_____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, no information can be discussed nor is treatment collaboration among the two parties possible. _____ (Initial)

A copy of this release shall have the same force and effect as the original.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Counselor: _____ Date: _____

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law. _____ (Initial)