Emergency Contact Release Form

Patricia K. Sullivan, LPCC-S, LICDC, CATP
House of Transformation Therapy Services LLC
Canton, OH
Phone: (330) 631-1319

Name:	**DOB:**

Provider/Requester: I hereby authorize Patricia K. Sullivan, LPCC-S, LICDC, CATP owner of House of Transformation Therapy Services LLC to release information to the following person(s) in the event of a medical or mental health emergency:

Primary (nearest in physical distance):

Emergency Contact Name:	
Address:	
Phone number:	

Secondary Contact Name

Emergency Contact Name:	
Address:	
Phone number:	

For the purpose of: **Care During a Medical or Mental Health (Suicidal/Homicidal) Emergency**

The information authorized to be released (please initial below)

	Any information related to a medical concern or emergency
	Any information needed to secure safety when suicidal or homicidal

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I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective one year after the date of my signature. A

photocopy or facsimile of this form may be accepted in lieu of the original signed form. I also understand that this consent is revocable except to the extent that action has been taken on it already.

I further understand that Patricia K. Sullivan, LPCC-S, LICDC, CATP will not condition my treatment on whether I give authorization for the requested disclosure.

Client signature	**Date**
Witness signature	**Date**

For office use only
Release valid from _____ to _____