Fresh Perspectives Counseling and Consultation Services, LLC

AUTHORIZATION FOR THE RELEASE OF HEALTHCARE RECORDS

Patient Name:____ (list maiden name/other names used)
Date of Birth:____________________________

I hereby request and authorize:

Fresh Perspectives Counseling and Consultation Services, LLC and
Chuck Lambertz, LSCSW, LCAC
101 E. 9th Street, Suite A
Concordia, KS 66901

_______**To Disclose information to:** _______**To Receive Information from:**

Provider____
Address____
City/State/Zip____
Phone Number____
Email Address____

Information to be disclosed include copies of:
_____Entire Record
_____Progress Notes
_____Other: ____
____

This authorization will be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

____ Date:______________
Signature of Patient

OR If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

______________________________________/________________________________Date:______________
Signature of Legal Representative/Relationship

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Witness ____