Judy Clark, LPC

Welcome Counseling Services
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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Judy CLark, LPC, DBA Welcome Counseling Services,** to release my information as described below:

Client Name (please print) _____ **Date of Birth** _____

Client's Representative (if applicable) _____ **Relationship to Client** _____

Persons/Organizations Providing Information	**Persons/Organizations Receiving Information**

Specific information to be released (including dates)[1]: _____

Purpose of disclosure: _____

I understand that electronic mail (e-mail) and wireless communication (cell phones) are not secure and be intercepted and read/heard by other people. I also understand that if the recipient authorized to receive the information is not a health care provider, the release of information may no longer be protected by federal and state privacy regulations[2].

The information may be shared by: ❒ Phone ❒ Fax ❒ Mail ❒ E-mail ❒ In person

Client (or Representative) must read and initial the following statements:

1. I understand that this authorization will expire on __/__/____. (mm/dd/yyyy) **Initials:** _____
2. I understand that I may revoke this authorization at any time by notifying Shea Alexander in writing. I also understand that if I choose to do so, it will not have any effect on actions taken prior to Shea Alexander receiving my withdrawal. **Initials:** _____
3. I understand that I may request to see and copy the information described on this form and that I will receive a copy of this completed form. **Initials:** _____

Client/Representative Signature _____ **Date** _____

Counselor's Signature _____ **Date** _____

[1]Under the Federal Substance Abuse Confidentiality Requirements, an authorization must include the purpose of the disclosure of substance abuse information even if the patient requests the disclosure.
[2]The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.