Stacey C. Stevens, LMHC

Consent for Release of Information

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH CLINICAL INFORMATION

Client Name: _____DOB: _____

I hereby authorize ***Stacey C.Stevens*** of
300 Center Rd. West Seneca NY, 14224 to exchange and receive information with:

My **Primary Care Physician named**: _____Phone # _____

Address:_____

Specific description of information contained in my Mental Health Clinical Record that may be used or disclosed under this authorization:

- Treatment Planning
- General Progress
- Case Impressions/Diagnosis
- Other :Medical history, medication, diagnoses
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I understand that my agreement to obtain or release information is necessary and that this permission is limited to **duration of service/ or one year from this date.** I understand that this consent may be withdrawn at anytime.

Refusal to sign this consent will not impact treatment.

_____/_____
Signature of responsible party date

_____/_____
Signature of Counselor date