Novo Counseling KC

Nicole Flynn MA,LPC *Rachelle Noll MS, LPC*

Kerry Kapetanovich MS, LPC *Heather Jones LSCSW, LCSW*

Authorization Consent to Release and/or Obtain Patient Information

I, _____ authorize the following information to be released:

For _____(client name) _____(date of birth)

_____ Assessment

_____ Diagnosis

_____ Treatment Plan

_____ Progress Notes

_____ Other:_____

From treatment dates: _____ **to** _____

Written form: **yes** **no** Verbal form: **yes** **no**

Information to be released to:

Name: _____ Agency: _____

Address: _____

Phone# _____ Fax# _____

Purpose of information:

_____ Treatment _____Assessment _____Care Coordination

Other: _____

I understand that this authorization expires one year from when it is signed unless otherwise indicated and that I have the right to revoke this authorization at any time. I understand that this information is protected by federal law confidentiality requirements and will not be released to others without my consent.

Signature: _____ **Date:** _____