Emotional Wellness Counseling PLLC

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Full Name _____ Date of Birth _____ Social Security Number _____/_____/_____

I hereby authorize Cynthia T. McCoy MS LPC to release information to:

Name: _____ Phone: _____

Address/City/State/Zip: _____

Information Requested: _____

Purpose or need for disclosure: _____

This information can be released: ___Verbally ____In Writing ____By Fax ____By E-mail

Information to be released for the following period of service: From _____to_____.

This authorization will expire: ____ Upon discharge from counseling services.
____ On the following date: _____.

This authorization may include, but is not limited to the release of information concerning the treatment of drug or alcohol use/abuse, drug related conditions, alcoholism, psychological/psychiatric conditions, HIV/AIDS related conditions and/or HIV testing.

This information is being disclosed from records protected by Federal confidentiality rules (42CFR Part 2). Re-disclosure of the information is strictly prohibited.

I understand this consent to disclose may be revoked by me at any time by written notice except to the extent that action has already been take therein.

I acknowledge that I have read and fully understand this authorization.

_____ _____
Signature of Client Date

_____ _____
Signature or Client Date

_____ _____
Signature of Witness Date