Balance Counseling
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AUTHORIZATION TO RELEASE/REQUEST INFORMATION

Client's Name_____ **Date of Birth**_____

I hereby authorize **LICIA THOMAS-WAGONER, LCSW** to ____ **release** and/or ____ **request** clinical information pertaining to my treatment in the form of the following:

- ☐ Initial Evaluation/Treatment Plan
- ☐ Treatment History
- ☐ Treatment Update
- ☐ Treatment Recommendations
- ☐ Discharge Summary
- ☐ Medical Records/Report
- ☐ School Records/Report
- ☐ Employment Records
- ☐ Psychological Evaluation
- ☐ Psychiatric Consultation
- ☐ Other: _____

To/From: Name: _____

Address: _____

_____

Phone: _____ Fax: _____

For the following purpose(s): coordination of care_____

This release is valid for one year unless otherwise noted. I have the right to revoke this authorization at any time by informing my therapist, LICIA THOMAS-WAGONER, LCSW in writing. However, my revocation will not be effective to the extent that my therapist has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

A PHOTOCOPY OF THIS COMPLETED FORM IS CONSIDERED AS VALID AS THE ORIGINAL.

Client Signature _____ Date_____
Parent/Guardian/Legal Representative Signature _____ Date_____