Counseling And Support Associates, PC
AT LAKE NORMAN

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize **Counseling And Support Associates, PC** to release and disclose information from the clinical record of:

____ (_______________)
(Name of client/recipient of mental health services) (Date of birth)

to, and allow such information to be inspected and copied by:

____
(Facility/Provider)

____
(Address)

Nature of information to be disclosed:

____
(State specific nature of information to be disclosed)

For the purposes of ____
(State specific purpose of information to be disclosed)

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to **Counseling And Support Associates, PC**. I understand that a revocation is not valid to the extent that **Counseling And Support Associates, PC** has acted in reliance on such authorization. This authorization is valid until ____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _______ no information released and/or ______________________

____.

A copy of this release shall have the same force and effect as the original.

______________________________________ ______________________________________
(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

______________________________________ ______________________________________
(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

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