Counseling And Support Associates, PC

AT LAKE NORMAN

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize _____
(Facility/Provider)

_____ to release
(Address)

_____
(State specific nature of information to be disclosed)

from the clinical record of_____ (_____)
(Name of client/recipient of mental health services) (Date of birth)

to Counseling And Support Associates, PC, 18515 Statesville Road #C-01, Cornelius, NC 28031, for the purposes of facilitating counseling/consultation, and/or conducting an evaluation.

I understand that 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 redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.

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