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**AUTHORIZATION & REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION
AND PRIVILEGED COMMUNICATION**

Client's Printed Name _____ Date of Birth: _____

I authorize my clinician: (Please check one)

- | | | |
|--|---|--|
| ☐ Melissa Beck, LCMFT | ☐ Katrina McFarland, LCMFT | ☐ Mikaela Wright, LPC |
| ☐ Kathi Bragg, BCLC, BHP | ☐ LaRon Moore, LPC | ☐ Hannah Leonard |
| ☐ Robert Bragg, LCMFT | ☐ Kevin Neuenswander, LPC | ☐ Raquel Rue |
| ☐ Chris Brunson, LCPC | ☐ Brennen Smith, LMFT | ☐ Glendon Thompson |
| ☐ CJ Byler, LSCSW | ☐ James Smith, LCMFT | ☐ Jeremy Fisher, Intern |
| ☐ Katy Fisher, LCMFT | ☐ Cheryl Tan, APRN | ☐ Melissa Meyer, Intern |
| ☐ Alison George, LCPC | ☐ Brooklyn Vogt, LMSW | ☐ Jennifer Willingham, Intern |
| ☐ Emily Jones, LPC | ☐ Emily Walter, TLMFT | |
| ☐ Tiffany Kelderhouse, LCPC | ☐ Blair Watkins, APRN, FNP-C, BSPH | |
| ☐ Hannah Lambert, LPC | ☐ Paul Williams, LPC | |

(Please check all that apply)

- ☐ To exchange information with:
- ☐ To obtain information from:
- ☐ To disclose information to:

Name: _____
Address: _____
City: _____ State _____ Zip _____
Telephone: _____
Email: _____

Initial appropriate blanks and circle which one applies:

- ____ Admission summary, discharge summary, psychological testing report, list of medications
- ____ School records (school progress notes, school intake evaluation, grades, attendance, IEP)
- ____ Psychological consultation report
- ____ Evaluation summary: Alcohol/DUI, Chemical Dependency, Sex Offender
- ____ Therapy notes including Treatment Plan (last 6 months)
- ____ Medical History: Medication checks, Lab reports (last 6 months)
- ____ Summary report of services received.
- ____ Consultation and/or verbal communication between the above-named parties
- ____ Other: _____

Expiration date: _____ (one year from date signed if not otherwise specified- effective for one year maximum).

I understand that my treatment will not be conditioned upon signing this authorization and that I have the right to revoke the authorization, except to the extent action has been taken or it has been relied on, by putting my revocation in writing and delivering it to the clinician identified above.

I issue this authorization with knowledge of the contents of the material and communication and understanding of the consequences and do so voluntarily and free from duress or undue influence.

I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above-named clinician from any liability relevant to the release of confidential information or privileged communication.

Client/Guardian Signature

Date

Client/Guardian Signature

Date

Clinician Signature

Date