

THERESA J. PAGE, MA, LPC

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Client Name: _____ D.O.B.: _____ SSN: _____

I specifically authorize Theresa J. Page, LPC to (initial) _____ Obtain information from and/or (initial) _____ Provide information to:

Name: _____ Address: _____
Phone: _____ Fax: _____

By initialing below, I authorize the information to be used on my behalf for the following purposes:

_____ Treatment planning _____ Coordination of care _____ Other as specified _____

By initialing below, I authorize release of the following medical records if such records exist:

- _____ Clinical office chart notes
- _____ Intake summary and treatment plans
- _____ Billing statements
- _____ Medical records needed for continuity of care
- _____ Other _____
- _____ HIV/AIDS related records*

*Must be initialed to be included in other documents

- _____ Mental health information
- _____ Drug/alcohol treatment and referral information**

**Federal regulation 42RF Part 2, requires a description of how much and what kind of information is to be disclosed.

- _____ This authorization is limited to the following treatment: *mental health treatment*
- _____ This authorization is limited to the following time period: *duration of treatment*
- _____ This authorization is limited to worker's compensation claim for injuries of _____ (date)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire in one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of client or personal authorized by law

Date