Compass Counseling and Consulting Services LLC

AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

Name of client:	
Date of Birth:	
SSN:	

I authorize the specific provider selected below:

[ ] Mrs. Brishen Lewis-Weir

To exchange the below-specified information regarding myself or the client to the individual(s) listed below:

Name: (name of person or facility)	
Address: (StreetAddress, City, State, ZIP)	
Phone:	
Fax:	

The information to be disclosed is marked below:

[ ] ALL records/information

-- OR --

[ ] Admission/discharge information **[ ] Treatment plan** **[ ] Scheduled appointments**

[ ] Compliance with treatment **[ ] Progress notes** **[ ] Discharge plans**

[ ] Psychological evaluation **[ ] Treatment summary** **[ ] Other:___________**

For the following purpose(s)____

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HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

[ ] Do NOT release HIV-related information [ ] Do NOT release drug and alcohol information

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I revoke this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 180 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Client name:______________________ Signature:________________ Date:______________

Guardian/Rep. Name:________________ Signature:________________ Date:______________

Witness name:_____________________ Signature:________________ Date:______________