Authorization for Release/Exchange of Information

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I, ____, herby authorize **LMV Counseling, PLLC** and
(Name of Individual)

____and the use of disclosure of my private
(Agency of Person to whom the requested disclosure will be made)

health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing. I understand this information will be used for determination of insurance benefits, to assist in the development of appropriate treatment goals, coordination of services between service providers, and/or advocacy on behalf of the client. I understand that I am not required to sign this form to receive services. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I have the right to seek assurances from the persons/organizations authorized to receive the information that they will not redisclose this information to any other party without my further authorization.

Notice to recipient on re-disclosure: Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug use disorder client. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested.

Information to be released (*initial* next to information to be released):

_____Mental health /Counseling information including assessments, progress notes, treatment summaries, psychiatric evaluation, notes & impressions, psychological assessments, case management assessments/notes, treatment participation, treatment recommendations, consultation by phone or face to face.
_____Educational Records (academic and behavioral)
_____Medical & Medication Information
_____HIV/AIDS Information
_____Family & Social Information
_____Substance Use or Abuse Information
_____Legal Information
_____Discharge plan

This authorization will expire one year from the date signed unless otherwise indicated. If you prefer a different expiration date, please specify here: ____________________ (Month/Day/Year)

I have read this Authorization for Release of Information, Fully understand its terms, and sign it freely, voluntarily, and without coercion.

Client's signature____ Date_______________

Signature of legal guardian (when required)____________________________ Date_______________

DOB: ______/______/______