IVORY HOWELL COUNSELING, LLC

AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION
FROM YOUR CLINICAL RECORD TO THE PERSON/ORGANIZATION YOU DESIGNATE

I, _____, DOB, _____,

Authorize Ivory Howell, LPCC to exchange information with: _____

Name/Organization: _____ Phone Number: _____

Address: _____ Fax Number: _____

Specific nature of information to be released:

☐any or all of the following
☐attendance/scheduling/transportation
☐information related to payment
☐presenting complaints/issues
☐diagnosis and/or assessment results
☐treatment plan and goals
☐summary of treatment
☐response to treatment/progress
☐prognosis
☐recommendations/suggestions
☐substance use information _____ initial

The information above is being released for the purpose of:

☐facilitating consultation and/or collaboration
☐facilitating continuity of treatment
☐facilitating scheduling/transportation
☐facilitating payment
☐facilitating family involvement in treatment
☐other: _____

I understand that:

1. This consent will automatically expire one year from signing unless a different date of expiration is specified here:
2. I have the right to copy and inspect the information being disclosed.
3. I have the right to revoke this authorization, in writing, at any time, by sending such written notification to my provider's office. My revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.
4. Treatment by Ivory Howell, LPCC is not necessarily conditioned on the signing of this document.
5. Once client allows release of information to any third party that there is a risk of re-disclosure by that party.
6. If am providing an electronic signature for this document and that I may request to sign a hard copy of this document if I prefer.
7. I have a right to a printed copy of this document.

Authorized Signature: _____ Date: _____

Witness: _____ Date: _____