SHANNON E. SMITH, LPC

Counseling, Consultation & Training

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize Shannon E. Smith, LPC, NCC to release and disclose information from the clinical record of:

_____ _____

Name of Client Date of Birth

to:_____ _____

Facility/Provider Relationship

_____

Address

_____ _____ _____

Telephone Fax Email

Nature of information to be disclosed:_____

State specific nature of information to be disclosed

For the purposes of _____

State specific purpose of information to be disclosed

This authorization is valid until _____.

Date or Event

*If no expiration date is specified, this authorization will expire six (6) months from the date of signature.

Important Information about Authorization:

You have the right to inspect and copy the information to be disclosed.

You have the right to revoke this authorization, in writing, at any time, but information released and disclosures made prior to that revocation cannot be taken back.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by our privacy policies.

A separate release is required for psychotherapy notes.

A copy of this release shall have the same force and effect as the original.

_____ _____

Client (or Guardian) Signature Date