Balanced Life Therapy
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REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

NAME: _____ BIRTH DATE: _____

ADDRESS: _____

PHONE: _____

I hereby authorize Michelle Hill Murray, LPC to receive/send psychological, psychiatric and/or personal information on the above named client to/from the following individual and/or facility.

PERSON OR FACILITY: _____

ADDRESS:_____

PHONE: _____ FAX: _____

A. I hereby authorize the source named above to send, as promptly as possible, the records on inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug/alcohol abuse.

B. I authorize the named above to speak by telephone with the person/facility about the reasons for client's referral, any relevant history or diagnoses, and other similar information that can assist with the client's receiving treatment or being evaluated or referred elsewhere.

C. I understand that no services will be denied the client solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for the client. The information disclosed may be used in connection with the client's treatment.

D. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization).

E. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

F. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the client, and arising out of an accident, injury, or occurrence to me/the client. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive.

G. I agree that a photocopy of this form is acceptable, but I, the releaser must sign it.

H. I know I may rescind this consent at anytime by providing a written revocation.

I. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

Signature of Client _____

Printed Name_____ Date_____

I, a mental health professional, have discussed the issues above with the client. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Professional _____

Printed Name_____ Date_____