Release Form

Pho: 828-638-5907
Fax: 828-322-2280

715 Fairgrove Church Rd SE Ste.202
Conover, NC 28613

Please complete the following information so I may coordinate services with other professionals. Initial in the box to the left of each contact listed and then sign and date at the bottom.

Client's Name:_____

I hereby authorize my therapist: _____ to exchange information necessary for assessment and facilitation with the following agencies/professionals:

Initials

☐ Contact Name:_____ Agency Name:_____
Address:_____ Phone:_____

☐ Contact Name:_____ Agency Name:_____
Address:_____ Phone:_____

☐ Contact Name:_____ Agency Name:_____
Address:_____ Phone:_____

☐ Contact Name:_____ Agency Name:_____
Address:_____ Phone:_____

I understand that this release will expire one year after date of signature for the purpose of any necessary follow-up. Prohibition of redisclosure: This information has been disclosed to you from the records whose confidentiality is protected by law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provisions of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

_____
Client or Guardian's Signature (18 yrs or older) Date

_____
Client or Guardian's Signature (18 yrs or older) Date

_____
Therapist's Signature Date