Katherine Latter Counseling, PC —*seeing you through the seasons of your life*

RELEASE OF INFORMATION

Authorization for the Disclosure of Records

Client Full Name ____Date of Birth: _________________

I, ____, hereby authorize my therapist, Katherine Latter, MA, LMHCA and Katherine Latter Counseling, PC to:

Disclose my confidential information to:	**Receive my confidential information from:**
Name: ______________________________	Name: ______________________________
Phone: ______________________________	Phone: ______________________________
Fax: ______________________________	Fax: ______________________________
Address: ______________________________	Address: ______________________________
______________________________	______________________________

I specifically authorize the release of the following (please check information to be disclosed):

______ Assessment and Diagnosis

______ Psychiatric/Mental Health Treatment Records Progress in Treatment

______ Drug and Alcohol Treatment Records

______ Evaluations Treatment Plans

______ School Records

______ Entire Health Record

______ Other - Specify:____

The above information will be used for the following purposes: diagnosis and treatment, coordination mental health and med- ical care, administration of health care service plans, coordination of family treatment and/or other (please specify):

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I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-dis- closed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it. This consent is effective for one (1) year from the date it is signed unless otherwise specified as follows:

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SIGNATURE
(All adult clients and, in the case of minors, their legal guardians)

DATE

SIGNATURE OF WITNESS

DATE