AUTHORIZATION FOR RELEASE OF INFORMATION

I/ We authorize Taylor Counseling Care, LLC to release and disclose information from the clinical record of:

____ (__________)

(Name of client/recipient of mental health services) (Date of birth)

In signing my name, I give permission for information to be inspected and copied by:

____

(Facility/Provider)

____

(Address)

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)

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Taylor Counseling Care, LLC. I understand that a revocation is not valid to the extent that Taylor Counseling Care, LLC has acted in reliance on such authorization. This authorization is valid until _________.

(Date)

It has been explained to me that if I refuse to consent to this release of information, my information will not be shared between any of my past or present healthcare providers.

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

____________________________________ ___________________________________

(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

________________________________ ____________________________

(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.