# RELEASE OF INFORMATION AUTHORIZATION FORM

CLIENT NAME _____

DATE OF BIRTH_____

ADDRESS _____

*I authorize disclosure of the following information, if such information exists, by Flatland Center for Brain, LLC.*

_____ Counseling, Clinical, or other information pertaining to services received at Life Spoken Counseling. This information may be released to:

Name: _____

Address: _____

Phone Number: _____

*I authorize disclosure of the following information, if such information exists, to Flatland Center for Brain, LLC.*

_____ Admission notes, discharge notes, treatment summaries pertaining to services received from/at:

Name of provider, practice or institution: _____

_____

Address: _____

Phone Number: _____

_____ Other (specify): _____

Purpose of obtaining or release this information: Continuity of Care: _____

Other (specify): _____

I understand that my access to Flatland Center for Brain, LLC services is not contingent on providing release of information. I understand that I may revoke this release at any time by giving written notice to Life Spoken Counseling. However, my request to revoke will not be in effect to the extent that information has already been disclosed as a result of this authorization. Unless revoked earlier, this authorization will remain in effect for one year from the date of client signature. I further acknowledge that the information to be released was explained to me and this consent is given of my own free will. I understand that Flatland Center for Brain, LLC is not responsible for potential re-disclosure of information by the recipient designated above. If authorization is for less than one year please provide expiration date: _____ _____

DATE CLIENT INITIALS

_____ _____

Client Signature Date