Phillips Mental Health Counseling, P.C

Form# 8: Authorization to Release Information

I, ___________________________, the undersigned give permission to Lynda Phillips LCMHC, to release the below stated records and provide to:

Name: ___________________________

Address: ____

____

Phone Number: __________________.

The following information (check all that apply)

- ☐ My attendance in therapy
- ☐ My diagnosis
- ☐ My treatment plan
- ☐ Information that is relevant to coordinating my care
- ☐ Treatment termination date and reason for termination
- ☐ Other, please explain in detail. ____

  ____

I understand that this release is valid for 120 days. I also understand that I may revoke this release of information authorization at any time.

In further consideration of this consent, I, ___________________at this moment release the above parties from any legal liability resulting from the release of this information.

Signature. ________________________. Print Name: ___________________

Date. ________________.

Revised 08/2021