

308 E. Lemon St. Ste 105 Lakeland, FL 33801 863-284-0817 fax: 863-284-0608 Catalyst Counseling LLC

Authorization to Release Confidential Information to Family Members/Friends

Name of patient: ______ Date of birth: ______Social Security #: ______

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life. To further this goal, I authorize this specific therapist <u>Norma Vaillette LMHC</u>, to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released may have a line drawn through them:

Name of therapist	Name of case manage	per Dame(s) of treatment p	rogram(s)	
Admission/discharge info	rmation 🏾 Treatment pl	an D Scheduled appointments	Progress notes	
□ Compliance with treatment □ Discharge plans □ Treatment summary □ Participation in therapy				
Psychological evaluation	Medications	Other:		

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

Name of person	Relationship			
Name of person	Relationship			
Name of person	Relationship			
Instructions and Limitations of Disclosure:				

p. 1 or 2 Authorization for Release of Information to Family Members

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire \Box one year from this date, \Box upon my discharge from treatment with Norma Vaillette LMHC, or \Box under these circumstances: ______.

Signature of client	Printed name	Date	
Signature of parent/guardian/representative	Printed name	Relationship	Date
I witnessed that the person understood the n was physically unable to provide a signature	•	ization and freely gave his o	or her consent, but
Signature of witness	Printed name	Date	
Signature of witness (a second witness is needed if person is unable to give oral consent)	Printed name	Relationship	Date
□ Copy for patient or parent/guardian □ 0	Copy for provider/therapist/	case manager 🛛 🖵 Copy	for family member