Norma J. Vaillette LMHC
215 East Oak Street
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 Norma Vaillette LMHC, 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(s) of treatment interventions(s)

❑ Admission/discharge information ❑ Treatment plan ❑ Scheduled appointments ❑ Progress notes

❑ Compliance with treatment ❑ Discharge plans ❑ Treatment summary ❑ Participation in therapy

❑ Evaluations ❑ 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: _____

_____

_____

_____

_____

_____

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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 ❑ one year from this date, ❑ upon my discharge from treatment with Norma Vaillette LMHC, or ❑ under these circumstances: _____ .

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/guardian/representative	Printed name	Relationship	Date

*(**witness** only if signed outside of office or if the person cannot provide a signature)*

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
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 ❑ Copy for provider/therapist/case manager ❑ Copy for family member