Patrick McKee, LCPC

Individual, Family and Group Psychotherapy for Children, Adolescents and Adults

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AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION

Client Name:_____ Date of Birth:_____

I, _____, hereby authorize Patrick McKee, LCPC &/or P4 Counseling & Wellness Center LLC to:

- ☐ Release information to
- ☐ Obtain information from
- ☐ Exchange information with

Name(s): _____

Agency: _____

Address: _____

Telephone: _____ Fax:_____

Please **initial** each category of specific information that you are allowing to be released. Write '**NO**' in categories of information that you are not allowing to be released.

_____Verification of services received
_____Dates of treatment
_____Treatment summary
_____Psychological assessment
_____Psychological counseling record
_____Progress Notes
_____HIV status

The information is being released for the following purpose(s):

- ☐ Coordination of treatment/care
- ☐ Submission for insurance coverage
- ☐ Family consultation and/or meeting
- ☐ Other _____

This consent will automatically expire one year after your last appointment with Patrick McKee, LCPC.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released). This revocation must be delivered in writing to each of the treatment providers listed above.

_____ _____
Signature of Client Date Signature of Parent or Guardian Date

_____
Signature of Witness Date

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