



Release of Information

Maria Potter Counseling Services, PLLC

Client's Name: _____

Date of Birth ____/____/____

Person or Organization with Whom Information can be Shared:

Name: _____

Email Address: _____

Phone Number: _____

Types of Information to be Shared:

- Entire treatment record
- Current status and location
- Billing statements
- Other: _____

Purpose of Disclosure:

- Continuity of care
- Emergency management
- Account management
- Other: _____

Duration and Revocation of Authorization:

This authorization is good for a period of 1 year. It will expire on ____/____/____ (today's signed date.).

- I understand that I can revoke this authorization at any time prior to that date by contacting the practice in writing.
- I understand that if the practice has already shared the information authorized here at the time I revoke this authorization, then it is too late to prevent that information from being shared.
- I understand that the practice cannot make completion of this authorization a condition for any treatments or benefits I am entitled to, unless this authorization is necessary to determine eligibility for treatment or benefits or to pay for treatments I receive.

Authorization:

I hereby authorize Maria Potter Counseling Services, LLC to release information as described above to, and request information from, the person or organization identified herein. I understand that the person or organization named above may not be subject to the same privacy laws and regulations as Maria Potter Counseling Services, LLC and may be able to further share the information disclosed under this authorization. I consent to use my handwritten signature for the purposes of validity, enforceability, and admissibility.

Client's Printed Name _____ Date _____

Client's Signature _____ Date _____
(Parent/Legal Guardian)