Transition Family Services

Tamika Reeves MA, LPC, NCC

Authorization to Release Information

Client's Name: Date of Birth:

I hereby authorize Transition Family Services to (check applicable): _____ obtain from the following
_____ release to the following

Name:

Address:

Phone:

The following documents/information to be released and or obtained:

Types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, progress/case notes, and summaries.

The records are required for the specific purpose of:

Continuity of care between Counselor and physician(s)_____
Emergency Contact_____
Continuity of care between Counselor and school_____
Other_____ _____

I understand that my authorization will remain effective from the date of my signature until _____, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

_____ _____
Signature of Consumer/Consumer's Designated Representative Date

_____ _____
Signature of Counselor Date