Shelley Diefenbach, LPC

Authorization to Release Information

I, ____, whose address is ____

____ do hereby consent and authorize **Shelley Diefenbach, LPC**,

_______ To release information to or _______ to receive information from:

Name: ____

Organization: ____

Address: ____

____

Phone: ____

Fax: ____

I authorize the release of this information _______ verbally or _______ in writing, by my signature below:

_______ Personal identifying information
_______ Education and school-related information
_______ Employment and work-related information
_______ Psycho-social history and related information
_______ Drug and alcohol information (for the sole purpose of assessment and/or treatment)
_______ Diagnosis and treatment recommendations
_______ Other ____

The authorized information is released only to the person named above. The information will be released with a warning that any further use of this information is a violation of confidentiality. I understand that this consent is revocable except to the extent that the action has been taken in reliance thereon and that this consent will remain in force until the date ___________________________________.

____
Signature of Client

____
Signature of Parent or Guardian

____
Printed Name of Client

____
Printed Name of Parent or Guardian

____
Date

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to Federal Law, federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.