AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION TO THERAPIST

I, *(person in interest)* ___________________________________, authorize (*person or organization permitted to release information*) _____________________________________ to disclose *(type, amount of, and time period of information to be disclosed)* **written and verbal reports regarding attendance, academic reports, psychological evaluations, behavioral and mental health status**

from the record of *(name and DOB of client whose information is to be disclosed)*

____

to Rupal Mistry, LCPC, who is providing services to me, whose address is:

7981 Eastern Avenue, Suite C-5
Silver Spring, MD 20910

for the purpose of *(purpose of the disclosure)*

Facilitation of Treatment

This authorization to release information is based on my understanding of the content of the records and the proposed use of the information once it is released.

If not previously revoked, this authorization will terminate on the earlier of one year or on the following specified date, event, or condition:
Close of Case

It is further understood that generally treatment cannot be conditioned upon the signing of this authorization except (*state any exception to this general rule or note "N.A."*):
N.A.

If this authorization is to be renewed after its expiration, it may be photocopied, but it must be signed again by me and by a witness.

SIGNATURE CLIENT: ____________________________________
DATE: _______________________

SIGNATURE OF PARENT (*FOR MINOR*) OR GUARDIAN):____
DATE: _________________________

SIGNATURE OF WITNESS:__________________________________
DATE: _______________________

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION BY THERAPIST

I, *(person in interest)* ________________________________, authorize Rupal Mistry, LCPC to disclose *(type, amount of, and time period of information to be disclosed)*

Referral information, attendance, assessment of behavioral and mental health status throughout treatment.

from the record of *(name and DOB of client whose information is to be disclosed)*

____

to *(name and address of requested recipient of the disclosed information)*

____

____

for the purpose of *(purpose of the disclosure)*

Facilitation of Treatment

This authorization to release information is based on my understanding of the content of the records and the proposed use of the information once it is released. I understand that, once this information is released, it is no longer protected, and while GUIDE may request that the recipient not further disclose the information, GUIDE cannot prevent the recipient from doing so.

This authorization is subject to revocation at any time in writing addressed to the Program Director at the site where I receive services except to the extent that the GUIDE Program, Inc. has already taken action in reliance on it. If not previously revoked, this authorization will terminate on the earlier of one year or on the following specified date, event, or condition:

Close of Case

It is further understood that generally treatment cannot be conditioned upon the signing of this authorization except (*state any exception to this general rule or note "N.A."*):

N.A.

If this authorization is to be renewed after its expiration, it may be photocopied, but it must be signed again by me and by a witness.

SIGNATURE CLIENT: ____

DATE: ________________________

SIGNATURE OF PARENT (*FOR MINOR*) OR GUARDIAN): ______________________________

DATE: __________________________

SIGNATURE OF WITNESS: ____

DATE: __________________________