|  |  |  |
| --- | --- | --- |
|  | ***R* 3 Counseling & Consulting Services**  Restore, Replenish, Reestablish  the Mind, Body, & Spirit | Kimberly L. Mason, Ph.D., LPC-S, NCC  509 Strawberry Lane  Madisonville, LA 70447  Tel. 985.326.9224  Fax: 800-660-2254  Kimberly.mason@r3ccs.com  www.R3ccs.com |

**Authorization/Request to Release Confidential Records and Information**

**I hereby authorize:**

Person/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To \_\_\_\_\_ (send) \_\_\_\_\_ (receive) information of records about:**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a minor Parent’s Name/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_ (to) \_\_\_\_\_ (from)**

Person/Agency: Dr. Kimberly Mason

Address: 509 Strawberry Lane, Madisonville, LA 70447

Phone Number: 985.326.9224

Fax: Fax: 800-660-2254

Email Address: [Kimberly.Mason@R3ccs.com](mailto:Kimberly.Mason@R3ccs.com)

For the following purpose: **Treatment Planning/Assessment**

**This release if valid from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

The information to be disclosed is marked by a check below:

|  |  |
| --- | --- |
| \_\_\_ Diagnosis  \_\_\_ Progress/Case notes  \_\_\_ Academic testing results  \_\_\_ Intelligence testing results  \_\_\_ Medical reports  \_\_\_ Personality profiles  \_\_\_ Evaluations | \_\_\_ Psychological testing results & reports  \_\_\_ Drug/Alcohol Test/Lab results  \_\_\_ Treatment Plan  \_\_\_ Medications  \_\_\_Mental Health Summary reports  \_\_\_ Entire Record  \_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

HIV related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: \_\_\_\_\_\_ do not release.

I have had this form explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent an action based on this consent has already been taken. This consent will expire automatically 1 year from the day on which it is signed, or upon fulfillment of the purpose stated above or otherwise agreed upon.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Representative Signature (if client is a minor) Relationship Date