New Outlook Counseling, LLC

Authorization for Release of Confidential Information

Date: _____

I hereby authorize Steven Perham, LMHC of New Outlook Counseling, LLC to:
❑ Obtain and/or ❑ Release confidential information regarding my psychotherapy services:

Client Name: _____ Date of Birth: _____

This information is authorized to be released to the following individual/organization:

Name: _____ Relationship: _____
Phone: _____ Fax: _____ Email: _____
Address: _____

Information is authorized to be released for the following reason(s):
❑ Continuity of care
❑ Confirm status of receiving counseling services
❑ Family member to be involved in treatment
❑ Other: _____

I authorize information to be released via the following methods:
❑ Telephone ❑Email ❑Fax ❑Verbal ❑Written

I understand that this consent may be revoked upon written notice and that this consent will remain in active until the following expiration date *(not to exceed 12 months):*
Expiration Date: _____

_____ _____
Client/Legal Guardian Signature (Specify Relationship) Date

_____ _____
Psychotherapist Signature Date

Revocation of Authorization of Release of Information
I hereby revoke my authorization for a release of information in writing as of the following date/time: **Date: _____ Time: _____** AM/PM

_____ _____
Client/Legal Guardian Signature (Specify Relationship) Date

_____ _____
Psychotherapist Signature Date