

## AUTHORIZATION TO RELEASE INFORMATION

I authorize Desired Outcomes / Kimberley Pollock, LPCC, CEAP to release to, and receive from:

Name: \_\_\_\_\_  
                    First                                    Middle                                    Last

Address: \_\_\_\_\_  
                    Street                                    City                                    State                    Zip

- School System                       Hospital                       Private Clinician  
 Physician                       Court System                       Other  
 Family Member/Support Person

the following information on: \_\_\_\_\_ (Patient Name)                      \_\_\_\_\_ (DOB)

- |  |   |
|--|---|
| _____ Medical Records                        | _____ Academic Records/Educational Evaluation |
| _____ Medical History/Physical               | _____ Treatment Plan/Patient Progress         |
| _____ Psychological Evaluation               | _____ Discharge Summary                       |
| _____ Social History                         | _____ IEP and/or Special Education File       |
| _____ Verification of Trmnt. Participation   | _____ Treatment Summary                       |
| _____ Results of Drug and Alcohol Assessment | _____ Other (specify): _____                  |

For the purpose of: \_\_\_\_\_

Approximate dates of service: \_\_\_\_\_

I have been informed of the type of information being released, the benefits and disadvantages, (if any), and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(If patient is a minor)

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

As required by Section 2.32(a) PROHIBITION ON DISCLOSURE – rule: “This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.”

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