Stepping Stones Counseling Services, LLC
Request For and Authorization to Release Information

Client's Name:_____ Date of Birth:_____

Client's Address:_____

Purpose of Release is to:

Transfer records:_____ Share information (verbal and written)_____

I hereby request and authorize my records from:

__To ____ From release the following information to:

Name:_____ Phone:_____

Address:_____

Relationship to Client: _____

Dates of Treatment: _____

Portion of medical record to be released:

___Diagnosis ___Medication ___Admission/Discharge info

___History ___Clinical History and Evaluation

___Consultant Notes ___Treatment Plan and Progress Summary

___Other (List) _____

You may withdraw this consent at any time by written notification to the facility, provided action has not been taken in reliance upon this authorization. Without written notice to withdraw this consent, it expires at the earlier of the listed expiration date or upon the release of information.

I am aware that when my medical records reflect information concerning psychological of psychiatric impairments, drug abuse, and/or alcoholism, and/or information regarding tests for or infection with human immunodeficiency virus (HIV) and other infectious diseases, that this information will be released as part of my medical record.

_____ _____

Client's Signature **Date**

_____ _____

Authorized Signature **Purpose of Signature**

Note: The execution of this form does not authorize the release of information other than specifically described. The information requested on this form is protected by State and Federal Laws and will authorize the release of information specified