•Kemper Orton, M.Ed., LMHC, NCC•

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

Name: ____ Date of Birth: _________________

Address: ____

City, State, Zip: ____

Telephone #: __________________________ Social Security #: ______-_______-______

I hereby authorize information regarding my treatment to be released as follows:

☐ From ☐ To ______________________________________ ___________________

(Name/Agency) (Telephone #)

____

(Address)

Please check the information you are authorizing to be released:

☐ Send a complete copy of my medical records to Kemper Orton, M.Ed., LMHC, NCC

☐ Share any and all information necessary for treatment planning and/or coordination of treatment

☐ Share only the following information: _________________________________

I understand that this authorization **expires exactly one (1) year** from the date of my signature below and I may revoke consent at any time, except to the extent that action has been taken in reliance therein or in life threatening circumstances. A copy of this release shall have the same force and effect as the original.

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

____ __________________

Signature of Client (or Parent/Guardian) Date

____ __________________

Printed Name Date

____ __________________

Witness Date

I hereby revoke my authorization: Name: _________________________ Date: _______________

Signature: ____

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