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Hicks Counseling Services

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Authorization for Release of Information or Records

Client Name (please print): _____DOB: _____

Authorized Representative-if different from client (please print): _____

Contact Phone: _____ Email: _____

I hereby give permission for Beverly Hicks, M.Ed., LPC to disclose clinical information and/or obtain information from:

☐ Family member ☐ Doctor ☐ Lawyer ☐ Hospital ☐ School ☐ Other: _____

Contact Name: _____ Phone: _____ Address_____

City, State: _____ Zip: _____

☐ Family member ☐ Doctor ☐ Lawyer ☐ Hospital ☐ School ☐ Other: _____

Contact Name: _____ Phone: _____ Address_____

City, State: _____ Zip: _____

☐ Family member ☐ Doctor ☐ Lawyer ☐ Hospital ☐ School ☐ Other: _____

Contact Name: _____ Phone: _____ Address_____

City, State: _____ Zip: _____

I am authorizing the following information to be released (please check only the area you want information release):

☐ Scheduling and/or billing purposes
☐ Phone Consultation (preferred)
☐ Attendance record only
☐ Diagnosis and assessment only
☐ Progress report on treatment
☐ Treatment recommendations only
☐ Other (specify)
_____

I may revoke this consent at any time with a written request. This authorization will expire one year after the date of this document.

Signature: _____ Date: _____

(client or authorized representative (parent of guardian)