



Hicks Counseling Services

Beverly Hicks, M.Ed.
NC: LCMHC, CCS, CADC
TX: LMFT, LCDC

2301 Stonehenge Drive. Ste.202
Raleigh, NC 27615

Office: 919.904.4257
Fax: 866.594.1848
www.hickscounseling.com

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., LCMHC 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 items you authorize to be released):

- | | |
|--|---|
| <input type="checkbox"/> Scheduling and/or billing information | <input type="checkbox"/> Progress report on treatment |
| <input type="checkbox"/> Phone Consultation (preferred) | <input type="checkbox"/> Treatment recommendations |
| <input type="checkbox"/> Attendance record | <input type="checkbox"/> Other (specify below) |
| <input type="checkbox"/> Diagnosis and assessment | _____ |

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)