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., 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):

____ Scheduling and/or billing information

____ Phone Consultation (preferred)

____ Attendance record

____ Diagnosis and assessment

____ Progress report on treatment

____ Treatment recommendations

____ Other (specify below)

_____

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)