

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this document, I, \_\_\_\_\_, hereby authorize Laurie Kingsley, MFT 35252,  
to disclose to and/or obtain information from \_\_\_\_\_ about  myself and/or  my minor child.

I authorize the above to exchange mental health records and information obtained during the course of treatment. I understand that I have a right to receive a copy of this authorization. The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If for other purposes, please specify:

I agree that the following information may be disclosed:

Any and all of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Medical management information | <input type="checkbox"/> Medical information                |
| <input type="checkbox"/> Assessment                     | <input type="checkbox"/> Educational or testing information |
| <input type="checkbox"/> Diagnosis                      | <input type="checkbox"/> Discharge/transfer summary         |
| <input type="checkbox"/> Psychosocial Evaluation        | <input type="checkbox"/> Progress in treatment              |
| <input type="checkbox"/> Psychiatric Evaluation         | <input type="checkbox"/> Demographic information            |
| <input type="checkbox"/> Treatment plan or summary      | <input type="checkbox"/> Financial/billing information      |
| <input type="checkbox"/> Current treatment update       | <input type="checkbox"/> Other: _____                       |

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Laurie Kingsley. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on this authorization.

Unless sooner revoked, this consent expires one year from the date signed below.

\_\_\_\_\_  
Signature of Client or Parent/Legal Guardian

\_\_\_\_\_  
Date