Alicia McArthur, MA, LCMHC
Seeds Counseling & Collaboration, PLLC

Authorization for Release of Information

I request and authorize ***Alicia McArthur, MA, LCMHC***, to **RELEASE** and/or **OBTAIN** (please circle one) from:

_____

_____

_____

Regarding (Patient): _____ DOB: _____

Address: _____

_____

I authorize the above named agency, persons or office to release _____

_____

_____ (specific information to be used or disclosed) either via verbal (telephone) or written information for the specific purpose of _____

_____

_____.

I hold harmless ***Alicia McArthur, LCMHC*** in regard to the use of information authorized for release of exchange. I understand that this form is not required as a condition for treatment and that it may be revoked in writing at any time, except to the extent that action has already been taken. In the absence of revocation, this authorization will expire one year from the date of my signature. A copy of this authorization is as authentic as the original signed Authorization of release. An original will be retained in my medical records. I fully understand what I just read.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____