unfold counseling llc

Authorization for Release or Exchange of Information

Patient's Name: ____ DOB: ____________________

I, _________________________ hereby authorize the RELEASE and EXCHANGE of Information TO or BETWEEN:

Name: Relationship:

Address: Phone:

Email: Fax:

AND

Karen Dunn Pritchard, LPC; Unfold Counseling LLC Relationship: *therapist*
Address: ***236 S. 3rd Street, #215, Montrose, CO 81401*** Phone: ***(970) 316 - 2424***
Email: ***karen.unfold@tsecuremail.com*** Fax: ***(888) 355 - 0737***

Reason for Release:

I hereby authorize the above-named individuals/entities to release and/or exchange information on the following, in regards to medical and mental health information:

- ☐ Presence in Treatment
- ☐ Initial Assessment/Diagnostic Summary
- ☐ Treatment Plans
- ☐ Financial Information
- ☐ Scheduling Information
- ☐ Discharge Summary/Aftercare Plan
- ☐ Medications
- ☐ Lab reports and physical exams
- ☐ Legal Information
- ☐ My Name and other identifying information
- ☐ ______________________________________
  ____

Indicate limitations, if any, of information to be released, and restrictions, if any, of how information is to be used. Or check, if no restrictions

Effective Dates: From Until end of treatment unless otherwise noted:

This voluntary consent is subject to revocation by the undersigned at any time except that action has been taken in reliance hereon, and if not earlier revoked it shall terminate at the above indicated date, the end of treatment, or twelve (12) months from the date of consent without express revocation.

Client Signature: **Date:**

Parent/Guardian Signature: ***Date:***

Therapist/Witness Signature: **Date:**