**Release to Obtain and Disclose Information**

I/We,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Shelly M. Smith, LPC, LMFT, to obtain and disclose pertinent information from my/our records to/from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of my/our request is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
I/We authorize the release of information:  
  
\_\_\_\_\_For one time only (within 90 days).  
  
\_\_\_\_\_For the duration of my/our counseling (up to one year).  
  
  
I understand that my records are protected under the Federal Confidentiality Regulations as well as the provisions of HIPAA of 1996 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time, provided that action has not been taken in reliance upon this authorization. Without written notice to withdraw this consent, it expires at the earlier of the listed expiration date or upon release of the information. The nature of this consent form has been explained to me/us and I/We understand its contents.  
  
  
I AM AWARE THAT WHEN MY MEDICAL RECORDS REFLECT INFORMATION CONCERNING PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, DRUG ABUSE, AND/OR ALCHOHOLISM, AND/OR INFORMATION REGARDING HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND OTHER INFECTIOUS DISEASES, THAT THIS INFORMATION WILL BE RELEASED AS PART OF MY MEDICAL RECORD.  
  
Client Signature(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Other Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Relationship to Client(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Signature of Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Signature of Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_