Mary Ann Mattingly, MS NCC RPT-S
Licensed Professional Counselor
Certified Clinical Mental Health Counselor
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RELEASE OF INFORMATION

I, ____, (DOB):______________, authorize Mary Ann Mattingly, MS, LPC, to release information to and obtain information from

____
____
____

For the purpose of planning, coordinating, and supporting my treatment.

(Read and initial all):

______ I understand that information shared may be in either written or verbal format.

______ I understand that information shared may include substance abuse history, HIV status, and psychiatric treatment.

______ I understand that any information disclosure carries with it the potential for unauthorized re-disclosure which may not be protected by federal confidentiality rules.

Specifically I authorize the sharing of information regarding (Initial all that apply):

_______ Admissions/Intakes/Assessments
_______ Discharge Summaries
_______ Medication Records
_______ Diagnoses
_______ Psychiatric Evaluations
Other: (Specify) __________________

I understand that I can revoke this authorization at any time. My revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire one year from date of signature or on
____.

____
Client/Patient Signature

____
Date

____
Clinician/Therapist Signature

____
Date