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Consent for Release of Confidential Information

I, _____, authorize **Kim Kays, M.S., LPC, LCDC and Kimberlee Kays, PLLC** to release/receive the following information:

- Verbal summary of individual counseling progress/goals
- Psychiatric evaluation results
- Progress notes/discharge summary
- Psychotherapy notes
- Medication management
- Billing (dates of service) and financial only
- Intake documents
- Assessment/testing reports
- Other _____

To/From:

Name: _____

Address, City, State & Zip: _____

Phone: _____ Fax: _____

For the following dates of service: _____

For the purpose of: _____

My signature means that I have read this form and/or had it read to me and explained in language I can understand. I understand this authorization/release is effective for 12 months from the below date and can be revoked at any time with the written request of either party. Information cannot be further disclosed by recipient to another party.

Client date of birth: _____

Client/Parent/Legal Guardian

Date

Witness

Date