Anissa Howard LPC, NCC
Counseling and Psychotherapy Services
507 N Davis Drive Suite 1A • Warner Robins, GA 31093
Phone: (478) 238-3795• Fax: (478) 202-9018

Authorization For Release of Information

I _____ do hereby request that Anissa Howard of Anissa Howard Counseling & Psychotherapy Services, LLC engage in the following as it relates to my records.

In accordance with this request, I hereby release and forever discharge and agree to hold harmless and indemnify Anissa Howard of the Anissa Howard Counseling & Psychotherapy Services, LLC, and Anissa Howard Counseling & Psychotherapy Services, LLC staff and employees from any and all claims, demands, damages, actions or suits of law or in equity of whatever kind which might arise in accordance with my request.

Purpose of Disclosure:

_____ Continued Care

_____ Personal Knowledge

____ Employment

_____ Insurance

____ Legal

_____ Other _____

Additional information about purpose of disclosure:

_____

_____

_____ Please have the following information **from** an outside person/provider/agency conveyed to Anissa Howard of Anissa Howard Counseling & Psychotherapy Services, LLC.

_____ Please have Anissa Howard of Anissa Howard Counseling & Psychotherapy Services, LLC convey the following information **to** an outside person/provider/agency (allow two weeks to process)

Check all desired:

_____ Assessment/Diagnosis

_____ Psychological/Psychosocial Evaluation

_____ Medication Management Information

_____ Progress in Treatment

____ Nursing/Medical Information

_____ Current Treatment Update

_____ Treatment Plan or Summary

_____ Other _____

_____ Presence/Participation in Treatment

_____ Exclusions (items not to be disclosed) _____

How would you like this information communicated?

_____ Verbal Discussion _____ Written Information _____ Other _____

Office Use Only:
Needs discussed with Client by:_____ date:_____
Information released: _____ date: _____
Released to: _____ by: _____

_____
Outside person/provider/title

_____
Name of agency/affiliation/relationship

_____
Mailing Address: Street, City, and Zip Code

_____
Phone and Fax Number

I understand this authorization is voluntary and not a condition of treatment. This authorization is automatically void after 1 year, and may be terminated by me at any time with a written notice, effective as of the date of signature. Information sent and/or received through this authorization may not be re-released to another individual or agency with the exception of medical or life threatening emergencies.
I may revoke authorization at any time, but my revocation is not effective until delivered in writing to Anissa Howard of Anissa Howard Counseling & Psychotherapy Services, LLC and is not effective as to health records already disclosed under this authorization. A copy of this authorization and notation concerning the persons or agencies to whom disclosure was made will also be included with my original health records.

☐ I do **not** wish to authorize any release of information at this time

_____ _____
Name of Client (print) Name of Guardian or Representative (print)

_____ _____
Signature of Client Signature of Guardian or Representative

____ - ____- ____ _____/_____/_____
Social Security Number Date of Birth

_____ _____
Client Contact Number Witness Signature

_____ _____
Date Date