Authorization for Release of Information

Stacey Laves-Khalifa, LPC, LMFT, LCDC

RE: ______________________________ Birthdate: ______________________________

Address: ____

This will authorize ____
(Name and Address)

to release to Stacey Laves-Khalifa information from the clinical record maintained while I and/or persons under my guardianship was/are a client at the above facility during ______________
Date

The information to be disclosed is:

____________________ Summary of Social/Family History

____________________ Summary of Psychiatric History

____________________ Summary of Medical History

____________________ Discharge Summary

____________________ Psychological Testing

____________________ Other (specify) ______________________________

For the purpose of ____

____

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose(s), this consent will automatically expire without my express revocation.

____
Client or Guardian Signature

____
Date Signed

____
Relation to Client