Harmony Counseling Services

257 Main Street, Harmony, PA. 16037

Authorization for Release and Exchange of Information with:

Maria Kitay, MA, NCC, LPC_____ **Alicia Leggett, MSCP_____**

Dennis Curcio, MA, NCC, LPC_____ **Sharon Sutton, MSCP_____**

I, _____ (DOB_____), hereby authorize the release and exchange of information of release and exchange of information of _____ (DOB_____) specified below between _____.

Print Therapist's Name

Name(s):

Address:
Phone:
Fax:

Purpose of the disclosure authorized (as specific as possible):

• Coordination of Care • Referral • Payment • Other _____

Data may be released in written, verbal, or electronic form and may include copies of the following information: (Please check all applicable information)

__Psychiatric Evaluation __Psychological/Educational Testing

__ Service/Treatment Plan __Alcohol or Substance Abuse History and Tx

__General Progress in Treatment __Discharge Summary __Other: _____

This doctrine of authorization of release has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is truly voluntary. This consent is subject to revocation by written instructions of the undersigned at any time. Further, I understand that this consent shall expire and must, if needed, be re-obtained twelve (12) months from the date below.

_____ _____

Client Name (Print) **Provider Signature**

_____ _____

Client Signature **Date**