Amy E. Brown, MS, CADC, LPC, CCTP
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610.416.0793

Release of Confidential Information

Name _____ Date of Birth _____

I grant Amy E. Brown, MS, CADC, LPC, CCTP explicit permission to release my protected health information (PHI) to: _____

This permission includes telephone contact as needed for consultation, evaluation, and treatment

Purpose(s) of information release (check all that apply):
□ Work □ Coordination of Care
□ Legal □ Medical
□ School □ Other (specify)_____

Specific information to be released (check all that apply):
□ Presence in treatment □ Evaluation results and recommendations
□ Treatment attendance □ Other (specify) _____
□ Results of lab tests
□ Exclusions _____

This release of information includes Psychiatric/Psychological, Educational, Drug/Alcohol/Substance Abuse, AIDS/HIV, Social Work, Medical, and Legal records and information unless specifically excluded.
This release will expire after one year unless otherwise revoked.

_____
Client Name

_____
Signature Date

_____
Guardian Name (if client is under 18)

_____
Signature Date

_____
Witness Name

_____
Witness Signature Date