Danisha Reed, LPC, ACS

Serving Atlantic County

609-447-2419

info@sugarcounseling.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to SUGAR Counseling, LLC by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____ authorize SUGAR Counseling, LLC to:

_____ release to:

_____ obtain from:

_____ exchange with:

_____

_____

_____

_____

the following information pertaining to myself:

_____ treatment summary

_____ history/intake

_____ diagnosis

_____ psychological test results

_____ psychiatric evaluation/medication history

_____ dates of treatment attendance

_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts

_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event

_____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____

Signature of Client Date

Date of Birth:_____

_____

Signature of Witness Date