MENTAL MATTERS CLINICAL SERVICES, LLC
MARRIAGE AND FAMILY COUNSELING
INDIVIDUAL PSYCHOTHERAPY
ADDICTIONS COUNSELING

Consent to Release Information

I, _____, hereby authorize Alphonso Lewis to exchange with, disclose to, or obtain from:

_____
Name of person or agency/representative

_____
Address

_____
City, State, ZIP

The following records of my professional/clinical relationship with the above. The nature and extent of this information to be disclosed is:

- ☐ Psychiatric Evaluation
- ☐ Progress/therapy notes
- ☐ History & Physical/Lab Work
- ☐ Medical/Psychological Tests
- ☐ Treatment/Service Plan
- ☐ Discharge Instructions
- ☐ Medical Records/Consults
- ☐ Other

The disclosure of records is being made for the purpose of treatment planning for the above-named individual. I understand that I may revoke this consent at any time except to the extent that action has already been taken on this authorization. I understand that this authorization shall expire one year from the date that the authorization is given, with or without my written revocation.

_____
Name of client or consenting person

Alphonso Lewis,
Printed name of witness

_____
Signature of client or consenting person

_____
Signature of witness

_____
Date

Therapist
Relationship to client/patient

Notice to the person or organization whom disclosure is made

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42CFR, Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. General authorization for release of medical records or other information is not sufficient for this purpose.