Heather L. Rice, LMHC, PLLC

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Request/Authorization to Release Confidential Records and Information

I hereby authorize Heather L. Rice, LMHC, PLLC, PO Box 3092, Oswego, NY, 315-529-1008, Fax: 315-295-2549 to discuss treatment options with and/or release information records regarding _____, dob:_____ to/from (facility and person)_____,
(address)_____,
(phone)_____, (fax)_____.

For the following purpose(s):
___further mental health evaluation, treatment, care
___treatment planning
___research
___rehabilitation program development or services
___other:_____

These records concern the time between (date)_____to (date)_____. If client has been discharged, this release is valid for 90 days after discharge date of _____. Please mark the information to be disclosed below with an "X". Written dates indicate when those records were mailed to the requestor.

___intake and discharge summaries
___mental health evaluations
___educational records
___other
___medical history and evaluation(s)
___developmental and/or social history
___progress notes, treatment /closing summary

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may rescind this consent at any time within 90 days, except to the extent that action based on this consent has already occurred. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Signature of client:_____Date: _____
Printed name of client:_____
Signature of Parent/Guardian (if client under 18): _____Date:_____
Printed name of Parent/Guardian:_____
Relationship:_____Date:_____