Your Space Counseling, LLC Roseann Lynch NCC, LPC, RPT, CDC I

1621 Tongass Avenue, Suite 305
Ketchikan, AK 99901
907-247-5000
907-247-5001
info@lynchtherapy.com

# AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name_____ DOB:_____

Person/Organization Releasing Information_____

Person/Organization Receiving Information_____

Description of Information to be Released:

_____

The purpose of the release of this information is:_____

_____

I hereby authorize the use of disclosure of health care and/or other information as described above. I understand that these records *may* contain sensitive information. I understand that I may revoke this information at any time by signing the revocation section on this release or by notifying the individual or organization releasing this information in writing, but if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individual or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on_____

Signature **of Client**_____ Date_____

Signature **of Parent** (if client is a minor child)_____ Date_____

Signature **of Witness**_____ Date_____

**I request that this authorization to release information be *revoked* effective_____. I understand that any action taken on this authorization prior to the revocation date is legal and binding. I understand that I can request a copy of this signed revocation. Signature_____ Date_____**