LifeCare Counseling
Psychotherapy Services Caring for You and Your Life

1293 Professional Drive, Suite A-101
Myrtle Beach, SC 29577
843.282.9004 office 843.808.6905 fax
lifecare@mylifecarecounseling.com

AUTHORIZATION FOR RELEASE OF INFORMATION

While sessions are confidential, signing this form allows your clinician to collaborate with anyone who may prove helpful to your mental health treatment including but not limited to a family member, loved one, medical providers, schools, referring agencies, etc.

I hereby give my informed consent to LifeCare Counseling Center, LLC to:

Disclose information to: ☐ Obtain information from: ☐ Exchange Information with:

_____ _____

_____ _____

_____ _____

LifeCare Counseling LLC
1293 Professional Dr, Ste A-101
Myrtle Beach, SC 29577
(843) 282-9004 office
(843) 808-6905 fax

Regarding copies of and/or discussions related to reports designated below for continuing treatment.

- ☐ Diagnostic Assessment
- ☐ Individual Plan of Care
- ☐ Progress Summary
- ☐ Session Notes
- ☐ Discharge Summary
- ☐ Continuity of Care
- ☐ Minor Client Treatment/Care
- ☐ Other (Specify): _____

Purpose of disclosure:

- ☐ Assessment & Treatment
- ☐ Discharge Planning
- ☐ Medical
- ☐ School
- ☐ Employer (FMLA
- ☐ Legal
- ☐ Personal Use
- ☐ Other:_____

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be in writing and will not affect information that has already been used or disclosed.
- This authorization will remain in effect for one year from the date signed unless revoked in writing.
- I understand that the information to be released may include information on the diagnosis and treatment of psychiatric/mental health disorders, alcohol/drug abuse, medications prescribed and any other protected health information concerning me.
  This excludes psychotherapy session notes unless explicitly requested.
- I further understand that if a person or entity to whom records and information are disclosed pursuant to this authorization are not covered by federal privacy regulations, this information will no longer be protected and may be redisclosed.

Client Name: _____ Client DOB: _____

Client Signature:_____ Date: _____

Parent/Guardian Signature: _____ Date: _____