Kristina Stephens Counseling

Campbell Counseling Group, PLLC

Authorization for Release of Confidential Information

I, _____ (Client's Name and/or Legal Guardian), Date of Birth _____, hereby authorize Kristina Stephens, MA, LPC, RPT, to release information to and receive information from:

_____

(Person/Organization) (Telephone Number)

_____

(Address)

I understand that the purpose of the disclosure is to comply with my request for Kristina Stephens Counseling to disclose information. The information to be disclosed includes:

( ) All mental health records ( ) Other: _____

( ) Progress in Treatment

( ) Diagnosis

( ) Treatment Plan

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be redisclosed by the recipient named above and at that time would no longer be protected by Kristina Stephens Counseling. I agree that a photocopy or facsimile of this authorization is as valid as an original. This authorization for release of information will expire one year after the date it was signed.

Date: _____

_____ _____

Printed Name of Client Signature of Client

_____ _____

Printed Name of Witness Signature of Witness

_____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian