RELEASE OF INFORMATION

Today's Date ___/___/_____
Date Release Expires___/___/_____ _____ Six Months ___ One Year
Client Name: _____
Age ____ Sex _____ Date of Birth: _____

I hereby authorize ***Sue Daniel, PH.D., LMFT, LADC*** and/or staff to (check all that are applicable):

_____ Exchange information with:

_____ Request the release of information from:

_____ Release information to:

Name _____
Title _____
Street_____
City, State and Zip Code _____
Phone ( )_____ Fax ( )_____

Sue Daniel, PH.D., LMFT, LADC
Office Location: 2520 St. Rose Parkway, Suite 202E, Henderson, NV 89120
Mailing Address: 2764 N. Green Valley Parkway, No. 151, Henderson, NV 89014-2120
Phone: (702) 898-1711

The purpose of this release of information is to:

____ Coordinate treatment with other providers

____ Verify attendance

____ Evaluate status

____ Obtain assistance

____ Other _____
_____.

Authorization and Signature:
I authorize the release of my confidential protected information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Client Name: _____ Date: _____

Client Signature: _____

If the Client is a minor, Name and Signature of Parent/Guardian:

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Witness Signature: _____