CANDY SMITH, MS, LCPC, RPT, SEP

COMPASSIONATE COUNSELING

*AUTHORIZATION TO OBTAIN OR RELEASE CONFIDENTIAL RECORS AND INFORMATION.*

*CLIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*I hereby authorize the following person or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive:*

***Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Please forward the records to Candy Smith, MS, LCPC at 11111 Nall Rd. Suite 200 Leawood KS 66211 913 232-1960***

***The information release is for the following purpose(s):***

***\_\_\_\_\_\_\_\_further mental health evaluation, treatment or care***

***\_\_\_\_\_\_\_\_\_\_\_\_Other***

***The records concern the time between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***The information to be disclosed is marked by an X in the boxes below.***

***\_\_\_\_\_\_\_\_\_\_\_\_\_Medical history and evaluations***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_Developmental and or social history***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatment history***

***\_\_\_\_\_\_\_\_\_\_\_\_\_Mental Health History***

***\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Records***

***\_\_\_\_\_\_\_\_\_\_\_\_\_Others/please specify***

***My signature below acknowledges my understanding of the following.***

***I understand I am authorizing the release of confidential records and information. I understand their content and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke my consent at any time within 90 days except to the extent that any action based on this consent has already been taken I understand that I have the right to receive a copy of this release and to request to view the information released by this consent.***

***This consent will expire automatically after 360 days from the date on which it is signed, or upon fulfillment of response from above named facility or person for the purposes stated above.***

***Signature***

***Printed Name***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relation to client***

***Date***

***A photo copy of this release will be considered valid.***

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