RELEASE OF INFORMATION

Client Name:_____________________________________ Date:______________________________

I hereby authorize Lori Kimmerly Therapy and Coaching, PLLC to release the following types of confidential client information:

- ❑ All Medical Records (specify)____
- ❑ All Psychological/Mental Health Records (specify)_________________________________
- ❑ All Court/Legal Information (specify)____
- ❑ Other (specify)____

Information is to be released to the following individual(s) institutions, or organizations:

Name/Organization: ____

Address: ______________________________________ Phone: ___________________________

FAX: ______________ E-mail: ___________________________

Please note: Information released pursuant to this consent is confidential. Further disclosure to other persons or agencies is forbidden by federal law without specific written consent of the client with the exception of quality assurance, peer review, supervision, fiscal audits, and compulsory process, where such information is kept confidential.

This consent will expire 90 days after termination of treatment with Lori Kimmerly Therapy and Coaching, PLLC. This consent may be revoked by me in writing at any time except to the extent that previous action has been taken. I understand no information can be released without written permission. I further acknowledge that the information to be released and the purpose for this consent were explained to me and that *this consent is given of my own free will.*

____
Client's Signature

____
Witness Signature