IHS Psychotherapy and Counseling LLC
Norma Stevens, MS, NCC, LCPC
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, (name)_____DOB_____,
authorize: Norma Stevens, MS, NCC, LCPC of IHS Psychotherapy and Counseling, LLC to release confidential information to or obtain confidential information from:

Name:_____
Address:_____
_____

Phone:_____

The information is necessary for:	check
Diagnosis and evaluation.	
Treatment planning.	
To facilitate treatment.	

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. **Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.**

By signing this Authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners, health plans and other health care entities observe under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

I have reviewed this Authorization and I understand it.

Client:_____ Date:_____

TherapistWitness_____Date:_____