Lincoln Counseling Enrichment Associates

RELEASE OF INFORMATION

I hereby authorize the staff **of Lincoln Counseling and Enrichment Associates** to release mental health information obtained in the course of psychotherapy treatment to and receive information from:

_____

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time and that such revocation must be in writing.

This disclosure of information is required for the following purposes:

_____

_____

Such disclosure shall be limited to the following specific types of information:

_____

_____

I understand that unless I specify above, the information released shall include psychotherapy notes.

I understand that I have the right to refuse to sign this form and that my treatment will not be terminated if I do not authorize this release of information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPPA privacy rule.

I agree that a photocopy of this Release of Information shall be as valid as the original.

I understand that this Release of Information shall be valid for three years from the date of the signature unless withdrawn earlier in writing.

_____	_____
(Counselee)	(Date)
_____	_____
(Parent or Guardian)	(Witness)