Heidi L. Parker, LCSW
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Authorization to Release Confidential Information or Records

I, _____ *(client name),* authorize Heidi L. Parker to exchange information regarding my mental health treatment and diagnosis, both verbal and written, with the following individual and/or facility:

Name of Person and/or Facility: _____

_____

Address: _____

_____

Phone: _____ Fax: _____

I understand that under Federal and State law, my expressed consent is required to release any personal health information related to my mental health.

I understand that I may cancel this release at any time, except to the extent that the action has already been taken. Any cancellation or modification of this authorization must be in writing.

_____

Client Signature Date

_____

Parent/Guardian Signature *(if client is under 18 yrs. of age)* Date

Expiration Date: _____
(If expiration date is not specified, authorization is presumed valid for one year.)