Lepa Modie LCSW, PLLC

REQUEST FOR RELEASE OF RECORDS AND CONSENT TO DISCLOSE CLIENT INFORMATION

I hereby request that the following individual, agency, professional, etc., obtain client information, records, reports, documentation from Lepa Modie LCSW, PLLC for treatment purposes.

_____

Agency/Professional

_____

Address

_____

City **State** **Zip Code**

This release of information pertains to:

_____ _____

Client's name **Date of birth**

Information will be released by: **Ongoing communication** **Copy of Records**

This will authorize Lepa Modie LCSW, PLLC to disclose information to _____. Disclosed information is to include clinical observations, biological/psychological/social history, diagnostic impressions, course of treatment and any other relevant information needed to treat this client. No disclosure will be made with regards to HIV/AIDS or Substance abuse as outlined in state law without a court order.

This authorization for release of information may be revoked in writing at any time. Otherwise, this release will automatically expire two years from date signed.

_____

Printed name of client or guardian

_____ _____

Signature of client or guardian **Date**

_____ _____

Signature of witness (Therapist) **Date**