Lepa Modie LCSW, PLLC

REQUEST FOR RELEASE OF RECORDS AND CONSENT TO DISCLOSE CLIENT INFORMATION

I hereby request that Lepa Modie LCSW, PLLC, obtain records, reports, and client information from the following:

_____

Agency/Professional

_____

Address

_____

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

This release of information pertains to

_____ _____

Client's name **Date of Birth**

This will authorize _____ to disclose information to Lepa Modie LCSW, PLLC 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 (G.S. 130A-143) or Substance abuse (42 CFR Part 2)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 one year from date signed.

_____

Printed name of client

_____ _____

Signature of client **Date/Time**

_____ _____

Signature of Witness (Therapist) **Date/Time**