Peter J. Sanderson
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LMFT, MHP, CMHS

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Authorization to Release, Receive, and Exchange Information

I, _____
(Please print your full name)

hereby authorize Peter J. Sanderson, LMFT, MHP, CMHS, to

☐ release to

☐ receive from

☐ exchange information with

(Name of person and/or organization) _____

(Address and/or Telephone Number of person and/or organization) _____

_____

This authorization covers only the following: (please initial all the items you wish released):

1. _____ Assessment and Diagnostic Information.
2. _____ Treatment information.
3. _____ Medication information.
4. _____ Summary of diagnosis, treatment, and/or prognosis.
5. _____ Frequency and scope of treatment.
6. _____ Other (please specify below).

_____

_____

I understand that my express, written consent is required to release any health care information relating to psychiatric disorders or mental health issues, testing, diagnosis, and/or treatment of HIV (AIDS) or other sexually transmitted diseases, and drug, alcohol or other substance use or abuse.

This released information may be used solely for health care treatment, insurance claim, or legal purposes. This authorization expires at end of treatment, or 90 days from the date on which it was signed, whichever occurs last. It may be revoked at any time by written, signed, and delivered request.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if under 13) Date