EMERGENCY CONTACT RELEASE FORM

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NPI: 1255758736

CLIENT NAME _____

SS# _____

DOB _____

I hereby authorize Anna Lively, LMHC to release information to the following person in the event of a medical or mental health emergency:

Emergency Contact Name: _____

Address: _____

Phone number: _____

For the purpose of:

CARE OR COORDINATION OF CARE DURING A MEDICAL OR MENTAL HEALTH EMERGENCY

The information authorized to be released :

- Any information related to a medical concern or emergency
- Any information needed to secure safety when client is at risk of harm or abuse of self or another, suicidality or homicidality

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for one year after the date of my signature. A photocopy or facsimile of this form may be accepted in lieu of the original signed form. I also understand that this consent is revocable except to the extent that action has been taken on it already.

I further understand that my provider, Anna Lively, LMHC, will not condition my treatment on whether I give authorization for the requested disclosure.

_____(sign) Date: _____

Client Name (Printed):

Parent/Guardian Signature (if child under age 14)