Release of Information and Records

Client's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, authorize Anna Lively, M.S., LMHC to release my records, including: assessments, psychological, medical and counseling records

- ☐ Intake documents
- ☐ Diagnoses
- ☐ Treatment Summary
- ☐ Treatment Plan
- ☐ Assessments
- ☐ Progress notes
- ☐ Billing and attendance records
- ☐ Any and all records that are a part of my file
- ☐ Other

This information is to be released to (THIRD PARTY):

_____

_____

For the purpose of:

_____

_____

This release specifically authorizes Anna Lively, LMHC. to discuss my treatment and/or my records with named THIRD PARTY with or without my being present for such conversation or discussion.

A copy of this release will hold the same validity as the original. I understand that I have a right to refuse to sign this authorization and that Anna Lively, M.S., LMHC ; LivelyTherapy; Mental Wellness Center; SCC United Methodist Church, is released from all legal liability that may arise from the release of the information requested. If this Release is to release an Assessment to a third party (inclusive but not limited to a substance assessment) – PLEASE NOTE – any assessment given is NOT guaranteed to meet the needs of said agency.

Signature of client: _____
(or legal guardian)

Date: _____