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## Authorization to Release Confidential Information

**Client Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby give permission for Steve Shealy, PhD to disclose psychological, educational, alcohol and/or drug abuse information, or any other records that he may have concerning me that are of a sensitive nature. This information may be released through copies of records, viewing of records by the agency/individual listed below or by verbal exchange.

**This information is to be released to:** (receiving agency/individual) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**for the purpose of (e.g. treatment planning)** \_\_\_\_\_

**The specific information to be released is: (e.g. via brief case summary or phone call, an overview of my work with Dr. Shealy and current issues and strengths)**

\_\_\_\_\_  
**Statement of understanding:** I understand a general medical authorization or subpoena duces tecum without specific authorization to release psychiatric or psychological information must have this waiver from the client or empowered representative. I understand that my records have a privileged and confidential status and that **I am waiving that status for the purpose contained within this authorization. I understand that I have a right to refuse to sign this authorization.** I understand this authorization may be revoked at any time upon written notification, but revocation has no effect on action already taken as a result of this authorization. I understand that any disclosure of this information by the receiving agency is prohibited by law.

This authorization is for a: ( ) **single** ( ) **continuing** disclosure, valid for 365 days after the date of my signature.

**Signature of Client** \_\_\_\_\_ **Date** \_\_\_\_\_

Signature of Representative (if minor) \_\_\_\_\_ Date \_\_\_\_\_

**Signature of Witness** \_\_\_\_\_ **Date** \_\_\_\_\_