Tammy L. Corrales, M.A., LPC-S

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AUTHORIZATION FOR RELEASE / EXCHANGE OF RECORDS OR INFORMATION

I understand that my records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization by writing the word "Revoke," along with my signature and the date across this form at any time after signed, except to the extent that action has been taken in reliance on it. I also understand that permission to release family records must come from all members of the family age 18 or over participating in the services, or information released must be restricted only to information regarding the person(s) who signs the release on behalf of him/herself or a minor child of whom they have legal rights to consent for treatment. If not previously revoked, this authorization will automatically expire one year following completion of services with this provider.

I authorize **Tammy L. Corrales, M.A., LPC-S,** to *[check all boxes that apply]*

[] To disclose information to: **AND / OR** [] To obtain information from:

[] ____
name phone fax

[] ____
name phone fax

[] My attorney: ____
name phone fax

[] Other party's attorney: ____
name phone fax

[] My child(ren)'s attorney: ____
name phone fax

[] Other: ____
name phone fax

Information to be disclosed / exchanged includes:

[] Any relevant information in my record
[] Only the following information [client must initial each item to be released / exchanged]

_____ Information regarding attendance at scheduled appointments
_____ Status with program: admitted, discharged, etc.
_____ Clinical records, including recommendations for additional services needed
_____ Other: ____

____
client name [please print] signature date

____
If client is under age 17, parent name [please print] signature date