Laura Thor, DMin, LCSW
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Client Authorization to Release Confidential Information

I, ______________________, date of birth ______, authorize Laura Thor, DMin, LCSW to:

(initial) release____ and/or (initial) obtain ____ information about my mental health care with Laura Thor, DMin, LCSW, with the following agency or person:

____name or

____agency

This form will be sent to the recipient by your preferred method below: (please provide)

______________________________ FAX

____postal address

___________________________________email ___________________phone call

This authorization expires 60 days after we end our counseling relationship, unless I receive your written/electronic instructions sooner. I cannot be held responsible for information that has already been released to your intended recipient before you rescind it. State Law will not permit me to re-release this information to any other entity. Minors age 15 and older can legally consent to receive mental health counseling and to release their private information to another provider without parental consent, however, I ask minor clients for cooperation in letting me inform their parents/ guardians only if considerable need arises, which I will discuss with you.

The information you allow me to release/obtain will include: (check all that apply)

X mental health and/or medical assessments, diagnoses, recommendations, medications, hospitalizations_
__legal proceedings __disability application
other:____
Restrictions:____

Signed:____**Date**_______

Print Name: ____

Co-signed (parent or co-client)____**Date**_________

Print Name:____