AFFINITY COUNSELING LLC

Susan M. Shanks, MDIV MAPC LPC LCPC CAMS-II

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AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize __**Affinity Counseling LLC / Susan M. Shanks,**
(Signature of client or parent/guardian)

MDIV, MA, LPC, LCPC, CAMS-II____ to release and disclose information from the clinical record of:

_____ (_____)
(Name of client/recipient of mental health services) *(Date of birth)*

to _____

_____
(Address)

Nature of information to be disclosed: _____
(State specific nature of information to be disclosed)

For the purposes of _____
(State specific purpose of information to be disclosed)

Treatment or payment is not conditional on permission to release information. I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Susan M. Shanks. I understand that a revocation is not valid to the extent that Susan M. Shanks, MDIV, MA, LPC, LCPC, CAMS-II has acted in reliance on such authorization. This authorization is valid until _____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences

(Specify, if any): _____.

A copy of this release shall have the same force and effect as the original.

_____ _____
(Signature of client or parent/guardian) *(Date)*

_____ _____
(Witness) *(Date)* *(Relationship)*

NOTICE TO RECEIVING FACILITY/THERAPIST:

- You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.
- I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.
- If the client /parent/guardian does not give an end date, this information is valid for 1 year from signature date.