AUTHORIZATION FOR RELEASE OF INFORMATION

LSS Counseling
745 Craig Road, Suite 206
Creve Coeur, MO 63141
314-409-2362

I (We) _____ hereby authorize LSS Counseling, Luann Spencer-Steele, to

( ) Release to ( ) Receive from ( ) Exchange information with

_____

(Name of party) (Company, school, etc.) (Phone & Fax)

In regards to:_____
(Name of Client) (Date of Birth)

I authorize the release of:
( ) Billing records ( ) Dates of attendance ( ) Psychotherapy notes ( ) Prognosis
( ) Diagnosis ( ) Testing results ( ) Assessment information ( ) All information
( ) Recommendations ( ) Other_____

The purpose of this release is for:
( ) Coordination of treatment ( ) Use by employer ( ) Use by school
( ) Use in court ( ) Second opinion ( ) Other_____

I understand thatI have the right to revoke this authorization, in writing, at any time by sending notice to **Luann Spencer-Steele**. I understand that a revocation is not valid to the extent that **Luann Spencer-Steele** has acted in reliance on such authorization. This authorization is valid for six months or until _____.

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): _____ no information released and/or _____.

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

_____ _____
(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (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.