*Melissa Lowe, Ph.D., LPC, LMHC*

## ***Authorization for Release/Exchange of Information***

Client Name: Soc. Sec. No.

*Information Released/To/Exchanged/From* *Information Released/Exchanged/To/From*

Melissa Lowe, Ph.D.
797 Washington
Newton, Ma. 02460
303 819 5757

Facility/person:

Phone:

_ Assessment/Diagnosis
_Compliance with Treatment
_Medical Records
_Treatment Recommendations
_Attendance
_Treatment Plan
_Recommendations
_Progress Notes
_Progress Reports/Progress in Treatment
_Evaluation
_Treatment Prognosis
_Discharge Summary Prognosis

Purpose for release of information:
**Amount of Information to be Disclosed:** __Information covering the previous three months ___other amount of information (specifiy):
**Authorization to Release/Exchange Information:**
*I understand that the authorization shall remain in effect for 180 days from the date of my signature below, unless an earlier expiration date is specified in this space…( ). I also understand that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to* ***Dr. Melissa Lowe.*** *I hereby authorize the release and or exchange of the above identifying information from my records. I hereby release* ***Dr. Melissa Lowe*** *from all legal responsibility or liability that may arise from this authorization.*

Client Signature: Date:

Witness/Clinician signature: Date:

The information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR, Part 2), The Federal rules prohibit you from making any further disclosure of informatin unless further disclosure is expressely permitted by the person who this information pertains or as other-wise permitted by 42 CFR, Part 2. A general authorization is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate for prosecute any alcohol or drug consumer.

## Revocation of Authorization of Release of Information

I, , hereby revoke my permission for the release of information relating to my care and with the parties listed above. Further release of information should cease immediately.

Client Signature: Date: Time:
Clinician/Witness Signature: Date: