



ONE ANOTHER  
COUNSELING, LLC

Lynette Arthurton, MA, LMHC  
Licensed Mental Health Counselor  
License #MH11536

### Authorization to Disclose Information

Client Name: \_\_\_\_\_

I hereby authorize Lynette Arthurton, Licensed Mental Health Counselor, to disclose information regarding social, medical, psychiatric, drug and/or alcohol treatment as noted below for the purpose of treatment planning for myself to:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Such disclosure shall be limited to the information indicated below: (Please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Physician Discharge Summary | <input type="checkbox"/> Clinical Treatment Summary   |
| <input type="checkbox"/> Psychosocial Evaluation     | <input type="checkbox"/> History/Physical Examination |
| <input type="checkbox"/> Psychological Evaluation    | <input type="checkbox"/> Nursing Admission History    |
| <input type="checkbox"/> Psychiatric Evaluation      | <input type="checkbox"/> Progress Notes               |
| <input type="checkbox"/> Treatment Plans             | <input type="checkbox"/> Medication Records           |
| <input type="checkbox"/> Laboratory Records          | <input type="checkbox"/> Diagnosis                    |
| <input type="checkbox"/> Aftercare Records           | <input type="checkbox"/> Other: _____                 |

I have been informed of my rights regarding the release of confidential information. The authorization will be valid for six months and limited to the information requested above. This disclosure of information is at my own request. I may revoke this authorization in writing at any time and I am aware that this information may be re-disclosed by my request. I understand that treatment and payment are not conditional based upon this authorization.

\_\_\_\_\_  
Date Client Signature

\_\_\_\_\_  
Date Legal Guardian/Representative Relationship to Client

\_\_\_\_\_  
Date Witness (Office Staff Member)

***The client must receive a copy of this signed authorization.***