ONE ANOTHER
COUNSELING, LLC

Lynette Arthurton, MA, LMHC
Licensed Mental Health Counselor
License #MH11536
Tax ID 46-2200531

PH: 813-785-6477 Fax: 866-311-0780

Authorization to Disclose Information

Client Name: ____

I hereby authorize: Name: _______________________

Phone No: ______________ Fax No: ________________

to disclose information regarding social, medical, psychiatric, drug and/or alcohol treatment as noted below for the purpose of treatment planning for myself to:

Lynette Arthurton
Licensed Mental Health Counselor
License # MH11536
2824 Wingduard Circle Suite 102
Wesley Chapel, FL 33544

Phone: 813-785-6477
Fax: 866-311-0780

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

- ☐ Physician Discharge Summary
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plans
- ☐ Laboratory Records
- ☐ Aftercare Records
- ☐ Clinical Treatment Summary
- ☐ History/Physical Examination
- ☐ Nursing Admission History
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Diagnosis
- ☐ 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