



## Consent for Release of Information

Name: \_\_\_\_\_, \_\_\_\_\_ Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

City\State: \_\_\_\_\_, \_\_\_\_\_

*I hereby authorize release of information so stipulated below.*

*Provider: Alden Lake Miller, MS LPC, DCC*

Recipient: \_\_\_\_\_ Title: \_\_\_\_\_

Mailing Address: : \_\_\_\_\_

City/State: \_\_\_\_\_, \_\_\_\_\_ Zip \_\_\_\_\_ USA/ \_\_\_\_\_

\*Information I want Released/Reason for Release:

\_\_\_\_\_ Dates of Service \_\_\_\_\_ Number of Sessions \_\_\_\_\_ Multiaxial Diagnosis

\_\_\_\_\_ Progress Summary \_\_\_\_\_ Progress Summary from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Other, specify \_\_\_\_\_

Information released is strictly confidential and is accepted for use solely by and for the parties, as stipulated above for the purpose of providing mental health and addiction services. I now authorize this release and stipulate **upon release this authorization expires unless otherwise noted:** \_\_\_\_\_ expires 2- weeks from now; \_\_\_\_\_ expires upon termination of treatment, or one year whichever occurs first. This information cannot be re-released by recipient without my expressed, written consent, unless determined by state/federal regulations, e.g., 42 CFR Part 2, and/or HIPAA regulations, AND except to which action has already taken place in good faith, as requested herein.

\_\_\_\_\_/\_\_\_\_\_

Client Signature/Date

\_\_\_\_\_/\_\_\_\_\_

Alden Lake Miller, MS LPC, DCC/Date

\*Charges may apply, please see [Fees](#)

- How To Start
- Services
- Fees
- Issues I Can Help
- Credentials
- About Me
- Policies
- Consent Forms
- Appointments
- Session Forms
- Contact Me
- Newsletter

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