

# Online Counseling & Psychotherapies

## Consent for Release of Information

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

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

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

Zip-Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

*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

**Sign and mail completed form to:**

Online Counseling & Psychotherapies  
PO Box 1056  
North Bend, OR 97459-0003