Alyse M. Scura, LMHC
NYS License #6008

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the provider by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Alyse M. Scura LMHC to:

☐release information to: _____

☐obtain information from: _____

☐exchange information with: _____

The following information pertaining to myself:

☐treatment summary

☐history/intake

☐diagnosis

☐psychological test results

☐psychiatric evaluation/medication history

☐dates of treatment attendance

☐other (specify) _____

For the purpose of:

☐evaluation/assessment and/or coordinating treatment efforts

☐other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition or event _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____

Signature of Client or Responsible Party and Date

_____

Printed name of Client or Responsible Party