Kristen L. Venit, MSW, LCSW
Counseling Services

Cameron Valley Psychotherapy
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Phone 704-594-3027
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Authorization to Release Information

Name of Client _____ Date of Birth _____

I authorize Kristen Venit (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

Name of Individual or Organization _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____

I authorize Therapy Changes to send the following information: (Check all that apply)

☐ Full Treatment Record
☐ Treatment Summary
☐ Initial Treatment Plan
☐ Dates of Treatment
☐ Psychiatric diagnosis(es)
☐ Other: _____

The above information will be used for the following purposes: (Check all that apply)

☐ Treatment Coordination
☐ Diagnostic Refinement
☐ Treatment Planning
☐ Other: _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective. I understand that this authorization will automatically expire after 1 year.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule

Signature _____ Date _____

Your relationship to the client: ☐ Self ☐ Other*

If other, please provide your legal name and relation to the client:

_____

*If you are not the client, you may be asked to provide documentation on your authority to act on behalf of this individual.