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# Consent and authorization to release psychological, medical, social, legal, and educational records

Pursuant to Federal Guidelines concerning my right to confidentiality, I,

Name: _____DOB: _____

Authorize: Dr. Christine Belaire

Belaire Counseling Services, LLC

To release, exchange, receive, and discuss information about:

Name: _____DOB: _____

Concerning/related to (Check all that apply):

| | | |
|---|---|---|
| ☐ Psychological records | ☐ Psychotherapy notes | ☐ Pharmacy records |
| ☐ Legal records | ☐ Social records | ☐ Billing/Payment |
| ☐ Phone records | ☐ Financial records | ☐ Other: _____ |
| ☐ Educational records | ☐ Medical records | _____ |

With the following person(s)/organization:

Name: _____ Email: _____

Company: _____ Address Line 1: _____

Phone: _____ Address Line 2: _____

I understand that I may revoke this consent to the release of information in writing at any time and that this consent will expire no later than sixty (60) days from the date of my last counseling appointment. I further understand that any release which has been made prior to my written revocation and was made in reliance upon this authorization shall not constitute a breach of my right of confidentiality.

Client Signature: _____ Date: _____