# SANDY GRAHAM, MS, PLLC

## AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize

_____

(Facility/Provider)

_____

(Address)

_____

(Phone) (Fax)

To release

☐ All records, without restriction ☐ All clinical records

☐ Progress notes and treatment plans ☐ Discharge summaries & recommendations

☐ _____

(State specific nature of information to be disclosed)

from the records of_____ (_____)

(Name of client/recipient of mental health services) (Date of birth)

to Sandy Richardson, MS, PLLC, for the purposes of facilitating treatment, counseling, consultation, and/or conducting an evaluation.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to the facility or provider named above. I understand that a revocation is not valid to the extent that the facility or provider has acted in reliance on such authorization. This authorization is valid until _____.

(Date)

If no expiration date is specified this authorization will expire one year from the date signed below.

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _____.

A copy of this release shall have the same force and effect as the original.

_____ _____

(Client Signature 12 yrs. or older) (Date)

_____ _____

(Witness) (Date)