Authorization to Release Information

I voluntarily authorize Level Wellness, LLC / R. Brian Pippinger, LMHC to:

Obtain from _____ Release to _____ Exchange with _____

_____ Name of Person

_____ Name of Facility/Practice

_____ Address

_____ City, State, Zip

_____ Telephone/ Written or verbal information

from the medical/therapy record of:

Name of Client/Patient _____ Date of Birth _____

This information is to be used for: (Check all that apply)

____ Coordination of Treatment

____ School Placement

____ Follow-up Care

____ Referral for Services

____ Legal Case

____ Other (Specify) _____

Specific information to be released: (Check all that apply)

____ Verbal Communication

____ Summary of Treatment

____ School Records/Information

____ Letter to Referral Source

____ Legal Records

____ Other (Specify) _____

_____ _____

Signature of Client Date

_____ _____

Signature of Client/ Parent/Legal Guardian Date