Amy E. Brown, MS, CADC, LPC
53 Darby Road ~ Suite F
Paoli, PA 19301
610.416.0793

Release of Confidential Information

Name _____ Date of Birth _____

I grant Amy E. Brown, MS, CADC, LPC, explicit permission to release my protected health information (PHI) to-or obtain my PHI from:

_____
(This permission includes telephone contact as needed for consultation, evaluation, and treatment)

Purpose(s) of information release: (check all that apply):
□ Coordination of care □ School Contact □ Legal matters
□ Other (specify) _____

Specific information to be released (check all that apply):
□ Presence in treatment □ Evaluation results and recommendations
□ Treatment attendance □ Treatment participation and progress
□ Results of lab tests □ Other (specify) _____
□ Exclusions: _____

This release of information Includes: Psychiatric/Psychological, Educational, Drug/Alcohol/Substance Abuse, AIDS/HIV, Social Work, Medical, and Legal records and information unless specifically excluded.
This release will expire after one year unless otherwise revoked.

Client signature _____ Date_____

Witness _____ Date_____

If client is under 14 years of age, please provide name and signature of parent/guardian:

Name (print) _____

Relationship to client _____

Signature_____ Date_____

Witness_____ Date_____