BEVERLY STUBBLEFIELD, LPC

Client Release Of Information

Client Name: _____ DOB: _____

I understand that by signing this form, I am allowing Beverly Stubblefield, LPC to disclose to and/or obtain information concerning the above named client to:

_____

Name of Person and/or Institution:_____

Mailing Address:_____

Phone:_____ Email:_____

Description of information to be disclosed:

Diagnosis	Clinical Assessment
Progress Notes	Treatment Plan
Progress In Treatment	Participation In Treatment
Clinical Consultation	

I authorize information to be released via electronic transfer, telephone contact, fax, email and/or mail. I understand that:

- I do not have to sign this authorization and my refusal will not affect my treatment.
- I may revoke this authorization at any time by submitting a written request.
- This authorization will expire one year from the date below.

I certify that this form has been fully explained to me and I understand its contents.

Client/Parent/Guardian Signature: _____ Date: _____

Relationship if not the Client: _____