

Laura Aube, MS, ATR-BC, LPC
Center for Creative Growth and Healing, LLC
406 Pine Street, Suite O
Raymore, Missouri 64083
816-359-1885

RELEASE OF INFORMATION

This form when completed and signed by you, authorizes Laura Aube, MS, LPC, ATR-BC to receive/disclose protected information from your clinical record to the person(s) you designate.

I, _____ hereby
(Name)
authorize the release of information regarding _____
(Name) (DOB)

This shall authorize Laura Aube, MS, LPC, ATR-BC to obtain/disclose/release information:

Organization: _____
Name: _____
Address: _____
Phone Number: _____

I am requesting Laura Aube, MS, LPC, ATR-BC to release this information for the following reasons:

This authorization shall remain in effect until (fill in expiration date) _____ or until (fill in an event that relates to the individual or the purpose of the use or disclosure) _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Laura Aube, MS, LPC, ATR-BC generally may not condition treatment services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Client

Date

Signature of Client's Legal Representative

Date

Relationship to Client

Signature of Witness

Date