KLC Support Services, LLC

Achieving peace, balance and a more fulfilling life

Authorization to Release Information Form

Client Name: _____ DOB: _____

Parent/Guardian: _____

Do hereby authorize Kimberly L. Censurato, LPC of KLC Support Services, LLC to exchange information to and from:

Name of organization &/or person: _____

Address: _____

Phone Number: _____

Fax Number: _____

The following information can be released (check all that apply)

_____ Diagnoses

_____ Assessments/Evaluations

_____ Treatment Goals

_____ Drug and Alcohol Issues

_____ Medication Management

_____ Lab Results

Other: _____ _____

Unless otherwise specified the purpose of this information is in the best interest of the identified client and needed to assist with treatment, assessment and continuity of care.

Other specifications: _____

This Authorization expires in one year from signature date or if requested otherwise.

Name of Client or Dependent: _____

Signature: _____ Date: _____

Witness: _____ Date: _____