Nicki Sindle, LPC-MHSP Counseling
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AUTHORIZATION FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

I, ______________________________, authorize Nicki Sindle, LPC-MHSP Counseling to

___release to

___obtain from

___exchange with

____

____

____

The following information pertaining to myself:

___treatment summary
___history intake
___diagnosis
___psychological testing results
___psychiatric evaluation
___dates of treatment/attendance
___psychosocial assessment
___nutritional assessment
___medical information
___progress in treatment
___progress notes

For the purpose of
___evaluation/assessment and/or coordinating treatment efforts
___other
This consent will expire one year after the date of my signature as it appears below, or on the following earlier date, condition, or event ______________________.

I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

___________________________ ____________________
Signature of Client Date