



# Evolve Counseling, PLLC

P.O. Box 152

Selmer, TN 38375

(731) 610-8862

## RELEASE OF INFORMATION

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_

Client Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### Recipient Information

I, \_\_\_\_\_, do hereby authorize Evolve Counseling, PLLC to release a copy of my mental health information to the person or facility below.

#### Name of person/facility to receive medical information:

\_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Authorization: \_\_\_ / \_\_\_ / \_\_\_\_\_ Authorization to expire on \_\_\_ / \_\_\_ / \_\_\_\_\_  
or upon the happening of the following event: \_\_\_\_\_

**Information to be Released** (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

My entire mental health record

Only those portions pertaining to: \_\_\_\_\_

Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)



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Other:

\_\_\_\_\_

Client's Name (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Psychotherapist's Name (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_