Life Transformations, LLC Holly R. Counts, Psy.D. 2670 Woodman Center Court Kettering, OH 45420 Phone: (937) 439-0505

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Request/Authorization to Release Confidential Records and Information

I hereby authorize:			
Person or facility:			
Address:			
Phone:	Fax:	Fax:	
to release information from records about	ut	, born on,	
and whose Social Security number is		, for the follow	ving purpose(s):
Further mental health evaluation, tre Continuity of care Legal issue Other:			
These records concern the time:			
The information to be disclosed is marke	ed by an X in the boxes below		
 Intake and discharge summaries Developmental and/or social history Psychiatric Evaluations Progress notes and/or treatment su Medication Records Other: 	/ Substa Psycho mmary Menta Educa	al history and evaluation ance abuse evaluations ological Testing I health evaluations tional records	(s)
Select only one: Please forward the records to the a Please forward the records to the a Please allow mutual exchange of in	ddress written above.	top of this form.	
HIV-related information and drug and alcohol information Do not release.	rmation contained in these records wi	Il be released under this cons	ent unless indicated here:
I have had explained to me and fully understand the their contents, and the consequences and implicate back this consent at any time, except to the extent after 180 days from the date on which it is signed,	ions of their release. This request is e that action based on this consent has	entirely voluntary on my part. I s already been taken. This cor	understand that I may take
Signature of client	Printed nam	e	Date
Signature of parent/guardian	Printed name	Relationship	 Date