Integrated Life Counseling Center, LLC
215 N Main St #205
West Bend, WI 53095

Release of Information

Client Name: ____ Date of Birth: ____________________

I hereby authorize Hadwat Sankari, LCSW at Integrated Life Counseling Center, LLC to disclose to (name and/or function of the person or entity to whom disclosure is to be made):

____

the following protected health information:

____ Entire File ____ Psychotherapy Notes ____ Session Start/Stop Times ____ Diagnosis

____ Treatment Plan ____ Symptoms ____ Prognosis ____ Progress to Date ____ Clinical Test Results

____ Modalities & Frequencies of Treatment Furnished ____ Dates of Treatment ____ Other

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective. I authorize the disclosure of the health information described above for the following purpose:

____

____

The specific uses and limitations on the uses of my health information by Recipient are as follows:

____

____

I understand that Provider cannot condition treatment upon me signing this authorization. The provider is authorized to disclose the protected health information specifically listed above until: ______________________________(authorization expiration date).

Client Signature: ______________________________________Date: _____________________________

If signed by other than Patient, please indicate the relationship between Patient and his/her representative: ____