LIFE SPRING COUNSELING CENTER
Authorization for Release of Confidential Information

Client Name: _____ Date of Birth:_____

I hereby authorize those listed below to disclose information to one another:

_____
Therapist Name
Life Spring Counseling Center
6859 W. Charleston Blvd.
Las Vegas, NV 89117
702-939-5433

_____
Name of Person or Agency
_____
Address
_____
City, State, Zip
_____
Phone

Information authorized to be disclosed includes:

- Diagnosis
- Treatment Plan
- Intake Evaluation
- Progress/Notes
- Discharge Summary
- Other (please specify): _____

Information being released for the purpose of: _____.

It is understood that the policy of Life Spring Counseling Center is to release only that information related to a current or former client who is considered essential to the purposes for which the authorization is requested. This in no way binds Life Spring Counseling Center to open its records for inspection or to provide information which may violate the above policy. Client records are protected by Federal Regulations, Nevada Statutes, and Administrative Regulations and any further disclosure is prohibited without the consent of the undersigned. Life Spring Counseling Services cannot guarantee that further disclosure will not occur.

A. I understand that this authorization is voluntary and that I may refuse to sign this authorization.
B. I understand that I may inspect or copy the information used or disclosed.
C. I understand that this authorization is effective immediately and that it is subject to revocation in writing at any time, except to the extent that action has already been take in reliance thereon. I may revoke this release in writing at any time and without penalty or denial of services.
D. I understand that this authorization will expire in one year from the date signed unless otherwise indicated.

I further release my therapist, the agency, and the staff of Life Spring Counseling Center from any liability arising from the release of information to the person/agency designated above.

_____ _____
Client Signature Date
Parent/Guardian of Minor

_____ _____
Therapist Signature Date