MaeDay Consulting Services, LLC

AUTHORIZATION TO DISCLOSE/RELEASE INFORMATION

Client Name: _____ Date of Birth: ___/___/_____

Social Security Number: _____

I hereby authorize the exchange and release of protected health records between:

Enrica Thomas, LMFT _____
4815 N. Preston Highway #6 _____
Shepherdsville, KY 40165 _____
(502) 627-0776 _____

The type of information I authorize to be exchanged/ released from/to Enrica Thomas, LMFT:

____Initial Evaluation/Assessment
____Treatment Plan
____Session Notes
____Compliance with treatment recommendations
____Medical Records
____Alcohol and Drug Use, Abuse Treatment Information
____OTHER:_____

Information may be communicated by phone, fax, email, mail, or in person. I understand I may request information be released in a more restrictive manner and have the right to inspect information disclosed.

I further understand that my treatment and services provided are not contingent on signing this release.

If other than client signing- I attest I have the legal rights to sign this release on behalf of the client.

I understand I have the right to revoke this consent at any time. I understand my intent to revoke this release must be done so in writing and given in person to the clinician, Enrica Thomas. This release will remain in effect until I request in writing for its revocation or 2 years from the date of signing.

Client/Guardian Date

Enrica Thomas, LMFT
4815 N. Preston Highway #6
Shepherdsville, KY 40165
502-627-0776 Office
888-972-4081 Fax
askenrica@enricathomas.com