Kent A. Tompkins, MA, LPC
Integrative Psychotherapy

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Liability Release: I understand this information is or may be protected by federal regulations and hereby release the individual named above from any liability associated with releasing OR RECEIVING SUCH INFORMATION. Your rights to confidentiality include protection from release of information regarding your diagnosis and treatment except by your written authorization or that of your authorized representative. Drug/Alcohol abuse information is protected under federal law CRF 42, Part 2, and may not be released except by written authorization.

PATIENT: _____
(Print Name)

AUTHORIZATION:

I authorize: Kent Tompkins, MA, LPC

_____

To release the information specified below to the following:

Release to: _____

_____

Confidential Records/Information to, including:

__ Psychiatric History & Treatment Summary
__ Alcoholism History & Treatment Summary
__ Drug Abuse History & Treatment Summary
__ Medical History & Treatment Summary
__ Other: _____

__ Employer Personnel Reports/Records
__ School Counseling Reports/Records
__ Probation /Parole Reports/Records
__ Exchange Information
__ Other: _____

_____ _____
Client Signature Date of Birth

_____ _____
Date of Request Parent/Guardian Signature

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