Resilient Families Counseling, LLC

Melissa Troskie, M.A., Ed.S., LPC, LMFT
212 Creekstone Ridge
Woodstock, GA 30188
(770) 744-3699
www.resilientfamiliescounseling.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Client Name: ________________________________ Date of Birth: ________________

I _______________________________________ authorize Melissa Troskie LPC, LMFT to:

_____ release to:
_____ obtain from:
_____ exchange with:

____
____
____
____

_____ any relevant confidential information about me

_____ limited confidential information about me as follows:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) ______________________________

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) ______________________________

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event __________________ ____. (See authorization extension form if needed).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

____ _______________________

Signature of Client Date
(If under 18 then the signature of parent or guardian)

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RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:
_____ 6 months OR
_____ other (specify) ____________________________

____ ________________________________
Client Date Witness Date

Check One:
_____ 6 months OR
_____ other (specify) ____________________________

____ ________________________________
Client Date Witness Date

Check One:
_____ 6 months OR
_____ other (specify) ____________________________

____ ________________________________
Client Date Witness Date