Release of Information

Client Name: _____ Date of Birth: _____

This is to authorize HIV, medical, mental health, alcohol/drug abuse treatment, legal, criminal, or personal information regarding the above-identified person to be released. Mind Space Mental Wellness Counseling LLC consists of Ashley Betz, MA, NCC, LPC. Records or information may be exchanged between Ashley Betz and:

_____
Name of Person/Entity to contact

_____
Address

_____
Phone/Fax

Information to be released: _____

Purpose: _____

**** This Release of Information Expires one year from the date of signature.****

This release may be revoked at any time either verbally or in writing, except to the extent that action has already been taken in reliance on the release. I acknowledge that some information may include material that is protected by State and Federal regulations including Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Information Portability and Accountability Act (HIPAA).

Client Signature: _____ Date: _____