Authorization for Release of Information
Cathy Weeg, LPC
565 University Avenue, Suite 4
Fairbanks, AK 99709
Ph 907-590-8384

Client Name:	Date of Birth:
Social Security Number:	

I hereby authorize Cathy Weeg, LPC to:
_____**Release Information to:** _____**Obtain Information from:**
Person/Agency:_____
Address:_____
City/State/Zip:_____
Phone#:_____Fax#:_____

Purpose of Disclosure *(Please check)*	**Information Requested** *(Please Circle)*	**Must Initial for Disclosure of:**
_____Treatment Planning _____Continued Treatment _____Coordinate Treatment _____Personal Use _____Legal Use _____Employment/Benefit Assistance _____Billing/Insurance _____Other (specify below) _____ _____ _____	Y/N Verbal Information **Medical Records** Y/N Medical: H&P, D/C Summary, Labs Y/N Psychiatric: H&P, Labs, Evaluations D/C Summary **Outpatient Records** Y/N Diagnosis/Reports/Treatment Notes/Labs Y/N Psychiatric Evaluations/Dr. Notes Y/N Intake/Case Notes Y/N Treatment Plans/Reviews Y/N Psychological Assessments Y/N Termination Summary Other_____ **Dates of Information to be Released** From_____To_____	____Psychological Information (i.e. diagnosis, case notes, intake, treatment plans, termination summary) ____Alcohol and Drug Information/ Treatment

1)My authorization is given voluntarily in writing for the above stated purpose(s) and will remain in effect for **ONE YEAR** from the date of signature OR through _____(up to one year). 2) I understand that by not signing this authorization it will not affect my treatment or payment for services provided by Cathy Weeg, LPC. 3) I may revoke (stop) this authorization at any time in writing, although it will not change any action taken between the date of original authorization and date the revocation is received by Cathy Weeg, LPC. 4) I may inspect or copy information to be used or disclosed pursuant to this authorization, copying fees may apply. 5) I am entitled to receive a copy of this authorization 6) I understand information released through this authorization might be re-disclosed by the recipient and may no longer be protected by Federal/State privacy regulations.

Client/Legal Representative_____ _____ **Date**_____
(signature) **(If client not signing, indicate representative's authority to act on client's behalf)**

Witness_____ _____ **Date**_____
(signature) **(print name here)**