CONNECTIONS COUNSELING, LLC
900 Corbitt Drive
Wilmore, KY 40390
Rhealynn Clark // 859-509-8468 // Rhealynn@kyconnections.com
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Request and Authorization for the Release of Information

Patient Information

Name: _____ Birth Date: _____

I, _____, authorize Connections Counseling, LLC. to: ☐ Receive from ☐ Disclose to

Name of Agency or Facility: _____

Street Address: _____ City/State/Zip _____

The following specific information will be received/disclosed from the above named patient's record:

☐ Evaluation/Assessment ☐ Treatment/Service ☐ Other: _____

Date(s) of treatment: _____

I understand the purpose of this disclosure is for: ☐ Use in treatment ☐ Other: _____

I hereby release the above named agency from all liability that may arise from the release of information requested. I expect that the information will be handled in a confidential manner.

Time Limitation: This authorization expires one year from the date of signature of the parent and/or guardian or client. This release is subject to revocation at any time. I acknowledge that I have read and fully understand this authorization.

Client/Parent/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____

Please send via mail to:

Connections Counseling, LLC
900 Corbitt Drive
Wilmore, KY 40390