



Authorization for the Release of Information

Client's Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Telephone No: _____ Alt. phone no: _____

I request and authorize Vicki L. Loyer, PhD, LMFT/Blue Door Psychotherapy to **release/receive** mental healthcare information of the client named above to/from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone _____ Phone _____

(home) _____ (cell) _____

This request and authorization applies to:

Mental healthcare information relating to the following treatment, condition, or dates: _____

All mental healthcare information

Other: _____

Client/parent/guardian _____ Date: _____

Client/parent/guardian _____ Date: _____

Client/parent/guardian _____ Date: _____

Client/parent/guardian _____ Date: _____

This release of information can be revoked at any time. This release will remain in effect until revoked in writing or 180 days from the date of signature or _____ (date). Where the behavioral health services are provided to more than one person in a family, each family member who is legally competent to consent to authorize release of client records shall sign a written authorization to release client records regarding that family member or any information obtained from that family member. Without such an authorization, information cannot be disclosed regarding that member's client record or any information obtained from that family member.