

Center for Child and Family Counseling, PLLC  
Release of Information

I, (Name of Client) \_\_\_\_\_, (Date) \_\_\_\_\_, authorize Center for Child and Family Counseling, PLLC, 1315 West Main St. Suite D, Lexington, KY 40508 to release information on my health information that may contain mental health, developmental disability and drug and/or alcohol treatment records to, and obtain such information from (Name/ Address/ Program and/or Title) \_\_\_\_\_

---

**Purpose:**

- |  |   |
|--|---|
| <input type="checkbox"/> Ongoing diagnosis                                   | <input type="checkbox"/> Legal  |
| <input type="checkbox"/> Treatment Planning                                  | <input type="checkbox"/> Application for health benefits              |
| <input type="checkbox"/> Social, vocational, fiscal, or educational planning | <input type="checkbox"/> Disability determination                     |
| <input type="checkbox"/> To report attendance at EAP assessment              | <input type="checkbox"/> To obtain payment of a health benefits claim |

**Scope:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Dates of hospitalization   | <input type="checkbox"/> Diagnosis                         | <input type="checkbox"/> Medical history and medications |
| <input type="checkbox"/> To report attendance at EAP assessment and agreement to follow through | <input type="checkbox"/> School Reports                    |  |
| <input type="checkbox"/> Psychiatric, social, psychological and other allied health evaluation  | <input type="checkbox"/> Reports of Progress and treatment |  |
|   | <input type="checkbox"/>                                   |  |

Redisclosure Notice: I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be protected by such laws.

Expiration Date: This release is good until the following date (s)/ events: ONE year. If not date is specified, this release will expire one (1) year from the date signed.

Your rights with respect to this release

- Right to inspect or copy the health information to be used or disclosed for this release: I understand that I have tot right to inspect or copy the health information I have authorized to be used or disclosed by this release.
- Right to receive a copy of this release: I understand that if I agree to sign this release, which I am not required to do, I shall be provided a copy of the signed copy of this release.
- Right to refuse to sign: I understand that this release is voluntary and that I may refuse to sign this release. Unless allowed by law, my refusal to sign this release will not affect my/ Client's ability to obtain treatment, receive payment or eligibility for benefits.
- Right to revoke release: I understand that written notification must be presented to Janet Vessels, M.S. LPCC in order to cancel this release. I understand that my withdrawal not be effective as to uses and/or disclosures of my /client's health information (i) already made in reliance on this release by the person (s) and/or organization (s) listed above or (ii) if this release was obtained as a condition of obtaining insurance coverage, to the extent that such person (s) and/or organization (s) have the right to contest a claim under the policy pursuant to which such coverage is provided, or the policy itself.

I have had an opportunity to review and understand the consent for release of information. By signing this release, I am confirming that it accurately reflects my wishes.

---

Signature of Client

Signature of Legal Representative

---

Date

Authority to Act for Client

Janet Vessels, M.S. LPCC RPT-S  
1315 West Main St. Suite D  
Lexington, KY 40508

859-913-9899 office  
www.yourkycounselor.com  
janetvessels@hotmail.com