Perkins
COUNSELING & PSYCHOLOGICAL SERVICES, PLLC

10580 Ligon Mill Road, #210
Wake Forest, NC 27587

Telephone: 919.263.9592
Fax: 919.263.9670

Authorization for Release of Protected Health Information

CONFIDENTIAL

Name of Patient: _____ DOB: _____
MM/ DD/ YYYY

Phone #: _____

I consent to allow the release and/or exchange of information between **Perkins Counseling & Psychological Services, PLLC** and

Name of Person/Agency: _____

Complete Address: _____

Telephone/Fax Number: _____

Information to be released:

_____ Psychiatric Records _____ Testing _____ Behavioral Observations/ Checklists
_____Therapy Notes _____ Treatment Plan _____ Laboratory Work
_____ Discharge Summary _____ **All of the Above** **OTHER:** _____

Purpose of Release: ***Coordination of Care***

I understand that I have the right to:

_____ Receive a copy of this authorization
_____ Refuse to sign this authorization
_____ Revoke this authorization at any time in writing

This authorization shall remain in effect until _____ or revoked in writing.

_____
Client Signature Date

_____
Parent/Guardian Signature Relationship Date