Kristin Faulkner, LISW-CP
North Grove Counseling Associates
240 North Grove Medical Park Drive
Spartanburg, SC 29303

P: 864.415.9152
F: 864.699.6386

Release of Information

I, _____, hereby authorize Kristin Faulkner to release information
(Client's Name)

to the following person/organization and for the following person/ organization to release information to Kristin Faulkner

_____ _____
(Person/Organization) (Phone Number)

_____ _____
(Address) (Fax Number)

for the purpose of: comply with client's request coordinate treatment plan

other: _____

I understand that authorization shall remain valid from the date of my signature below and for 1 year after the date it was signed or other:_____

I authorize the release of my confidential protected information as described in my direction above. I understand that this authorization is voluntary, that the information is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state law that limits the use and/or disclosure of my confidential protected health information.

I have been informed that I may revoke this authorization by written communication to Kristin Faulkner. I certify that this form has been fully explained to me and that I understand its contents.

Date Signed:_____

_____ _____
Printed Name of Client Signature of Client

_____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian