Sally Markley ATR, LPC

AUTHORIZATION TO RELEASE INFORMATION

I _____ authorize Sally Markley ATR, LPC to
Client/Guardian Name Date

☐ release information to ☐ obtain information from ☐ exchange information with

Name: _____

Agency: _____

Address: _____

Telephone #: _____ Fax #: _____

Information is limited to:

☐ Complete behavioral health record (Excludes substance abuse treatment)
☐ Assessments
☐ Diagnosis
☐ Summary Report
☐ Treatment Plans
☐ Transportation
☐ Progress notes
☐ Art work
☐ Dates of attendance/appts not kept
☐ Summary of treatment
☐ Substance abuse treatment (Initials_____)
☐ Billing, Payment and Insurance Purposes
☐ AIDS/HIV Related Information
☐ Substance Abuse (drug/alcohol) Records

Disclosure of information is for the purpose of:

☐ Coordination of care with another mental health professional
☐ Coordination of care with another health professional
☐ Resolution of a legal matter
☐ Other _____

I understand that the information that will be exchanged includes records in any form as well as discussion with the individual/entity authorized above. I understand that I can revoke this authorization at any time by simply making that request in writing to Ms. Markley at 2561-2 E. Ft Lowell Tucson AZ 85716

My authorization will expire one year from today or _____ (whichever date is sooner).

Client Name/DOB: _____ Date: _____

Signature: _____ Date: _____
Please Circle: Self Parent Gaurdian

Witness (if necessary): _____ Date: _____