Embrace Healing Therapy Center, LLC
Emileah Most, MS, LMFT

AUTHORIZATION TO RELEASE INFORMATION

Embrace Healing Therapy Center, LLC

Type of Disclosure:

☐ Psychiatric ☐ Psychological ☐ Addiction treatment ☐ Medical

☐ All Records ☐ Psychiatric Evaluation ☐ Psychological assessment

☐ School Records ☐ Chemical Health Assessment ☐ Telephone

☐ Financial

Purpose of Disclosure:

☐ Continuity of care

☐ ____

I understand that my records may be protected under the federal regulation governing confidentiality of alcohol and Drug Abuse Client Records, 42 CXR Prt. 2, and cannot be disclosed without my written consent unless otherwise provided for in regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

______________ (one year from today's date).

I ____ (client) **hereby authorize** Embrace Healing Therapy Center, LLC to exchange with, to obtain from, and to release to:

Name:____

Agency:____

Address:____

Phone:____ the information above.

Client Signature:____

Date:_________________________

Witness:____

Date:_________________________