The Elements Counseling Services, PA
Authorization to Release Confidential Information

Today's Date: _____
Client Name: _____ DOB:_____

I hereby authorize _____The Elements Counseling Services, PA /Cindy Baubach, MA, LCMHC__
to release/exchange and/or communicate specified information regarding my treatment to:

Name and Business: _____
Address: _____
City: _____ State:_____ Zip code:_____
Phone: _____ Fax: _____

Information to be released (check all that apply):
_____ Progress Notes _____ Psychotherapy Notes
_____ Drug Abuse treatment information _____ Alcohol abuse treatment information
_____ All my information maintained by The Elements Counseling Services, PA from _____(Date)
_____ Other: _____

Reason (s) for this authorization (check all that apply):
_____ At my request _____ Claims Management
_____ Treatment Planning _____ Coordination of Care
_____ Evaluation _____ Other: _____

This authorization ends: _____ (date not to exceed one year)
or, when the following event(s) occurs _____

I understand that I do not have to sign this release of information and that I may revoke this authorization in writing at any time. If I did, it would not affect any actions already taken by The Elements Counseling Services, PA

_____ or _____
Client's Signature Parent, guardian or legally appointed representative

_____ _____
Date Witness