Kimberly Le, MA, LPC, LCDC
www.kimletherapy.com

Authorization to Release Information

I, ____authorize

Kimberly Le, MA, LPC, LCDC ____________________________ and

____
(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release one to the other the following information from my records:

_______ All Health Care Information
Initials

_______ Health Care Information or Opinions Relating to any or all of the
Initials following treatment(s) and, or conditions:

_______ 1) Psychiatric or Mental Health Information
Initials

_______ 2) Academic and Confidential School Information
Initials

_______ 3) Testing
Initials

_______ 4) Other ____
Initials

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

____ _________________
Client Date

____ _________________
Parent or Legal Guardian Date

____ _________________
Witness Date

Kim Le Therapy
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