

Mary Ann Mattingly, MS NCC RPT-S

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RELEASE OF INFORMATION

I, _____, (DOB): _____,
authorize Mary Ann Mattingly, MS, LPC, to release information to and obtain information
from

For the purpose of planning, coordinating, and supporting my treatment.

(Read and initial all):

_____ I understand that information shared may be in either written or verbal format.

_____ I understand that information shared may include substance abuse history, HIV
status, and psychiatric treatment.

_____ I understand that any information disclosure carries with it the potential for
unauthorized re-disclosure which may not be protected by federal confidentiality rules.

Specifically I authorize the sharing of information regarding (Initial all that apply):

- | | |
|--------------------------------------|---------------------------|
| _____ Admissions/Intakes/Assessments | _____ Discharge Summaries |
| _____ Medication Records | _____ Diagnoses |
| _____ Psychiatric Evaluations | Other: (Specify) _____ |

I understand that I can revoke this authorization at any time. My revocation will not
apply to information that has already been released. Unless otherwise revoked, this
authorization will expire one year from date of signature or on

_____.

Client/Patient Signature

Date

Clinician/Therapist Signature

Date