

 **Melissa VanBeck**
M.S., L.M.H.C.
Counseling and Psychotherapy

**AUTHORIZATION FOR RELEASE OF
INFORMATION**

I, _____, date of birth: _____,

Authorize Melissa VanBeck to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Melissa VanBeck is authorized to:

- Send information to
- Talk to
- Receive information from
- Fax to
- Email

Persons/Organizations receiving and/or disclosing the information:

Name: _____

Agency/Relationship: _____

Address: _____

City/State/Zip: _____

Telephone #: _____ Fax: _____

Nature of the information to be disclosed:

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent (in writing) at any time unless action has already been taken as a result of this authorization.

I understand that my records may contain information regarding the diagnosis of treatment of HIV (AIDS) virus, other sexually transmitted diseases, drug and/or alcohol abuse. I give my specific authorization for these records to be released and do hereby release Melissa VanBeck from all legal responsibility that may arise from the release of the medical information hereby authorized

This release expires: _____

I have read the above authorization to release information. I understand it and authorization is hereby granted.

Date: _____

Signed: _____

Witnessed: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.