NADIA HUMPHREYS, MA LMHC
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AUTHORIZATION TO RELEASE/EXCHANGE PROTECTED INFORMATION

I, ____, authorize:
Client Name (Parent/Guardian for Minors)

Nadia Humphreys to release/exchange the following information to:

Name of Agency or Person: ____

____
Street   Zip Code   City

______________________________   ______________________________
Phone No.   Fax No.

- ❑ Psychiatric information
- ❑ Biopsychosocial history
- ❑ Therapy/counseling evaluations, progress reports, discharge summaries
- ❑ Medial records
- ❑ Employment information
- ❑ Legal information
- ❑ Information regarding past or current involvement with Child Protective Services (Vormundschaftsbehörde)
- ❑ School/Guidance information (including academic and behavioral progress)
- ❑ Other: ____

I understand that all information released or exchanged will be used for professional purposes only, and will not be released to third parties. The authorization may be revoked in writing at any time will automatically expire by the following date: ________________________.

Client Name: ____

Date of Birth: ____________________

____   ______________________________
Client Signature (Parent/Guardian Signature for Minors)   Date