BETH KILLIAN
MA, LMHC, NCC

AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my counselor, Beth Killian, to release the following:

_____

_____

This information should only be read to the following:

_____

_____

I am requesting my psychologist to release this information for the following reasons, and subject to the following limitations:

_____

_____

This authorization shall remain in effect until _____, or until _____. However, I understand that this Authorization does not permit disclosure of my future health care given more than 90 days from the date of this Authorization (unless this is for disclosures to insurance companies). If this Authorization does not contain an expiration date, the Authorization expires 90 days from the date of my signature.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my counselor's office address. However, my authorization will not be effective to the extent that the counselor has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party.

SIGNATURE DATE

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