Little Red Telescope

life unfolded

Authorization to Release Information

I, _____, the undersigned, give permission to Courtland McPherson, MSW, LCSW DBA Little Red Telescope to release to or obtain information from:

_____

(Name)

_____

(Address: City, State, Zip Code)

_____

(Phone Number)

the following information (check all that apply)

☐ my attendance in therapy

☐ my diagnosis

☐ my most recent physical evaluation by my primary care provider

☐ my treatment plan

☐ information relevant to coordinating care

☐ when treatment is terminated and why

☐ other (please explain in detail) _____

_____

- I understand that my records are protected under applicable law and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve alcohol or drug abuse, they are also protected under the Federal Regulation (42 CFR Part 2). Confidentiality of Alcohol and Drug Abuse Patient Records.
- I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information (including alcohol and drug abuse records of my condition and HIV test, if relevant) to those persons/agencies named above.
- I further release Courtland McPherson, MSW, LCSW DBA Little Red Telescope, agents and representatives from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

This authorization will have a duration of consent no longer than one year after the date of this form. I understand that I may revoke my consent at any time except to the extent that action has been taken in reliance on it.

_____ _____

Signature Date

Courtland McPherson, MSW, LCSW Lic. # LCSW 73960
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