Consent for Release of Information

Client Name: _____ __ Date of Birth: _____

I authorize LOVE LIFE THERAPY CENTER, LLC, 31 N 6th Ave, Suite 105-258, Tucson, AZ 85701 to

☐ Release ☐ Exchange Protected Health Information (PHI) to/with:

Organization/Individual: _____ ☐ Myself

Address: _____

Phone: _____ Fax: _____

Secure E-Mail: _____

Method of Release: ☐ Fax ☐ Mail ☐ Pick Up ☐ Telephone ☐ Other: _____

Purpose of Release: _____

Information Authorized: _____

_____

I hereby release Erin A. Lowry, LCSW and/or Love Life Therapy Center, LLC from any liability that may arise as a result of this authorization. I certify that I gave this consent freely and voluntarily, and understand that my right to receive services is not contingent upon my giving this consent. I may revoke this consent by notifying Erin A. Lowry of Love Life Therapy Center, LLC in writing at any time, except to the extent that Erin A. Lowry and/or Love Life Therapy Center, LLC acted on this consent before I revoked it. My consent automatically expires after **one year** unless an alternate date is specified _____.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above. I understand that the individual or agency who receives the record pertaining to this consent may NOT re-disclose the record to any individual or agency without a separate written consent from me, unless such recipient is a provider who makes a disclosure permitted by law.

I understand that if I agree to sign this authorization, I must be offered a signed copy of the form.

_____ _____

Signature of Client Date

_____

Printed Name of Client

_____

Signature of Parent/Guardian or other Authorized Representative

_____

Printed Name of Parent/Guardian or Other Authorized Representative

_____ _____ _____

Witness Signature Date