

**AUTHORIZATION TO RELEASE INFORMATION**

**CAROL ANN GRAYBEAL, MSW, LCSW, BCD  
ASSOCIATES IN COUNSELING AND PERSONAL DEVELOPMENT  
3 HOSPITAL DRIVE, SUITE 308  
LEWISBURG, PA 17837  
PHONE: (570) 523-7509 FAX: (570) 523-7599**

NAME \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ DOB \_\_\_\_\_

Provider/Requestor: I hereby authorize Carol Ann Graybeal to (release to) or (receive from):

\_\_\_\_\_  
(Name of Doctor, Hospital, Insurance Company or other Agency)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone number) (Fax number)

For the purpose of: Continued Care Insurance purposes Legal Personal

At the request of the patient \_\_\_\_\_ Other \_\_\_\_\_

The information to be released to or received from is:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Lab reports              | <input type="checkbox"/> Medications           |
| <input type="checkbox"/> Medical History        | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Treatment Plans       |
| <input type="checkbox"/> Progress Notes         | <input type="checkbox"/> Discharge Summary        | <input type="checkbox"/> Psychological History |
| <input type="checkbox"/> Discharge Plan         | <input type="checkbox"/> Psychological Testing    | <input type="checkbox"/> EKG/EEG               |
| <input type="checkbox"/> Other _____            |   |  |

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for six months after the date of my signature, unless specified below. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon.

SEE REVERSE SIDE (OVER)

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I further understand that Carol Ann Graybeal will not condition my treatment on whether I give authorization for the requested disclosure.

This consent shall be in effect from \_\_\_\_\_ until \_\_\_\_\_  
(not to exceed one year).

\_\_\_\_\_  
Signature of Patient (14 years or older)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Signature of Parent/Guardian  
(if patient is under 14 years old)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date of Signature

**SPECIAL AUTHORIZATION – PLEASE SIGN YOUR INITIALS NEXT TO THE INFORMATION TO BE RELEASED.**

\_\_\_\_\_ My evaluation, diagnosis and/or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the consent above.

\_\_\_\_\_ My evaluation, diagnosis and/or treatment concerning my mental health/rehabilitation and/or neuro-psychological testing/treatment may be released to the recipient noted on the consent above.

\_\_\_\_\_ My diagnosis, testing and/or treatment for HIV/AIDS may be released to the recipient noted on the consent above.

**(IF THE PATIENT IS UNDER 14 YEARS OF AGE, PARENT OR GUARDIAN MUST INITIAL.)**