Debra Kaplan, LLC
MA, LPC, LISAC, CMAT, CSAT-S
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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (HM) _____(WK) _____ Date of Birth: _____

I, _____, authorize Debra Kaplan Counseling to disclose the following information:

- ☐ Assessment Information
- ☐ Treatment Plan(s)
- ☐ Progress Notes
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Other: _____

Purpose of Disclosure:
_____
_____

Individual or agency to whom information is to be released: _____
_____
_____

I understand that my records are protected under federal regulations 42 CFR Part 2, governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Debra Kaplan Counseling is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event ***this consent expires automatically in 12 months*** from the time of last session. Initial _____

_____	_____	_____
Parent/Guardian	Signature	Date
_____	_____	_____
Client	Signature	Date
_____	_____	_____
Therapist	Signature	Date