Kathleen M Albert PhD
COMPLETE CARE COUNSELING, LLC
DBA One to One Psychological Services
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AUTHORIZATION TO REQUEST/ RELEASE INFORMATION

I hereby grant my permission for the following providers to release information about:

Client's Name: _____ **Date of Birth**: _____

1) Kathleen M. Albert, Ph.D. **to release** confidential information & material **to**:
_____

2) For _____ **to release** confidential information & material to Kathleen M. Albert, Ph.D.

Information may be conveyed by a phone call or sent to an above address.
Specific information/ material to be released:

___ Treatment Plan/ Reviews ___ Diagnosis/ Treatment notes ___ Psycho-Social History
___ Assessment & Eval. Info. ___ Psychiatric Eval./ Diagnosis ___ Discharge Summary
___ Medical History ___ Psychological Testing ___ Vocational Info.
___ Medication Reports ___ Academic Records ___ Updates and Progress
___ Other (specify) _____

This information and material authorized for release may be used only for the purpose(s) below. (Parent/ guardian must initial each approved purpose).

___ To coordinate or provide clinical services ___ To refer to other services
___ Follow-up ___ Treatment/ service planning
___ Discharge Planning ___ Other (specify)

I understand that no information or material will be released without this specific permission except where provided by law. I also understand that I have the right to review copies of any information or material released. I understand that I do not need to sign this form in order to receive services. I have the right to withdraw permission in writing at any time. Withdrawal of permission will not cover information/ material released by that date, but will prevent further release of information.

Unless otherwise revoked this release will expire on the specified date of _____.

_____ _____
Signature of client Date

_____ _____
Signature parent/ legal guardian Date