Kelley Parke, PhD, L.P.C.C.
Licensed Professional Clinical Counselor

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Authorization for the Use and Disclosure of Health Information

Federal law says that I cannot share your health information without your permission except in certain situations. If you sign this form, you are giving me permission to share and/or obtain the health information you indicate below. *This does not keep the information I release from being shared with more people once it leaves my office*. You may revoke this authorization any time in writing except to the extent that action has already been taken to comply with it.

Date: _____ Client's Name: _____

I give permission to Kelley Parke, LPCC to **release** the health information checked below to the following person or group _____

- ❑ All information
- ❑ Information from a certain time period (specify dates):
  From: _____ To: _____
- ❑ Other (specify): _____

I give permission to Kelley Parke, LPCC to **obtain** the health information checked below from the following person or group _____

- ❑ All information
- ❑ Information from a certain time period (specify dates):
  From: _____ To: _____
- ❑ Other (specify): _____

Client's Signature:_____ Date:_____

Signature of Authorized Representative:_____

Relationship of Authorized Representative:_____