Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

AUTHORIZATION FOR RELEASE OF INFORMATION

I/we authorize Alyssa Beer, LCSW, CFRC to disclose to and/or receive information only as stated below from the records of:

Client name: _____ DOB:_____

Release to/from: _____

Address: _____ Phone: _____

_____ Fax: _____

This may include:

- Mental Health Information
- Physical Health Information
- HIV Related Information
- Substance Abuse Information
- Evaluations, Recommendations
- Other (specify): _____

Dates for information to be used or disclosed: From _____ to _____

This authorization allows Alyssa Beer, LCSW, CFRC to send and request attendance dates, progress, summaries, reports, assessments, updates, medical records, and information related to treatment and the progress and discharges of treatment. The purpose for the disclosure will be only for coordination, treatment/therapeutic purposes, continuity of care, verification of participation, assessment, medication management, or compliance to a court order/subpoena. The information disclosed may be subject to re-disclosure and no longer protected.

By signing, I understand I have the right to revoke this Authorization at any time and must do so in writing. I may not revoke it to the extent that the Therapist has already relied upon it, or if the Authorization was signed as a condition of obtaining insurance coverage, or a continued court order/subpoena.

I have read this Authorization, or had it explained to me, and I understand it's contents.
I have_____ accepted _____ declined a copy of this release.

Signature: _____ Dated: _____

Print Full Name: _____

Witness: _____ Dated: _____

Expiration of Release of Information: _____

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