Let's Conquer This, LLC
17 Merline Ave
Erie, PA 16509

AUTHORIZATION FOR RELEASE OF INFORMATION TO AN ATTORNEY

I authorize Shannon O'Sullivan, LPC to disclose to and/or receive information only as stated below from the records of:

Client name: _____ DOB: _____

Release to/from: _____

Address/Phone: _____ Phone: _____

_____ Fax: _____

This may include:

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

_____ I understand that should I or my attorney require Shannon O'Sullivan, LPC to appear in court or provide records, a subpoena is required and I will be asked to sign a consent form. Should I not be available to sign a consent form or refuse to consent to this, I understand a court order will need to be authorized by the Judge. I understand this is to protect my mental health records in accordance with the PA Code of Ethics 49.72 and the National Association of Social Workers.

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: _____ Date: _____

Print Full Name: _____ Expiration Date: _____

Witness: _____