Rowan-Bailey Counseling, LLC, 12465 S. Fort St., #250, Draper, UT 84020
801-810-SRBC (7722)

Consent and Authorization for Release of Information

I, _____ (DOB: _____), give my consent and authorization for the release of my confidential protected health information to, from and between Stephanie Rowan-Bailey, LCMHC of Rowan-Bailey Counseling LLC and the following entities indicated below to facilitate understanding and support, and to aid in continuing care in the counseling process.

Agency	Individual Name	Address	Telephone
Family Member or Significant Other			
Medical Community	*Physician:*		
	Therapist/Counselor:		
Law Enforcement			
Schools	*Teacher/Counselor:*		
Other			

I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions as follows:

- Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- Psychological or psychiatric evaluation(s), reports, assessments, routine progress notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Social, family, educational, and vocational histories
- Evaluations and reports of consultants
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
- Complete copy of the medical record including psychotherapy notes.
- Other: _____

The purpose of my authorization is:

- To disclose the information at my request
- For the following purposes: _____

Dates of care included: From _____ to _____

I understand that I have the right to revoke this authorization at any time by giving written notice of my revocation to the person/entities listed in the boxes above. If not previously revoked, this authorization will terminate on the earliest of the following dates:

- one year from the signature date below, or
- 4 weeks after counseling services have ended with Stephanie Rowan-Bailey, LCMHC.

_____ _____ _____ _____

Client Signature Date Therapist Signature Date