Roseanne T. Myers, MS, NCC, LPC
2461 Lititz Pike
Lancaster, PA 17601
717-208-2149

Release of Information

Permission is given to____
to release to or obtain information from Roseanne T. Myers, MS, NCC, LPC regarding

____
(Name of Client) (Date of Birth)

The information released or obtained will be for the purpose of diagnostic assessment and treatment planning.
I authorize the request/disclosure of my information as described below:
□ Psychiatric/Psychological Evaluation and treatment summaries
□School records, testing results and /or school performance
□Abstract of medical records (verbal & written communication, medication history including allergies, updates)
□Legal communications
□Verbal communications Dates:___________________________
I understand that the information in my health care record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

I understand that once the information is released, we are no longer accountable for it’s use. I further understand that my consent to release information will expire in one (1) year unless I withdraw my consent in writing, and that withdrawing my consent will not apply to information that has already been released.

___________________________________ ___________________________________
Client Signature & Date Parent/Legal Guardian Signature & Date

____
Client’s Name (Please Print)

____
Witness Signature & Date