

Tools4Life LLC.

Psychotherapy & Counseling
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AUTHORIZATION TO RELEASE INFORMATION GENERAL CONSENT FORM

I, (Client, Patient Name) _____, DOB _____, authorize Tools4Life LLC./Rebecca J. Hedgecock, NCC, LPC to:

Exchange information with: _____ Release information to: _____

Agency/Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

The following identifying information from my records (specify type, extent, or nature of information to be disclosed) note* blanket authorization such as "all information" will not be honored.

Report of psychological evaluation, progress notes, and/or:

The purpose or need for such disclosure is for current treatment, and/or:

This consent to release information may be revoked by me in writing any time except to the extent that disclosure has already occurred. This consent (unless expressly revoked earlier) expires upon _____.

This consent to release/exchange information via electronic methods i.e. fax and/or email. Initial: _____

Signature of Client/Patient: _____ Date: _____

Specify Relationship: _____

Signature of Witness: _____