Authorization to Release Information

I, ________________________, authorize, and agree to hereby give my full and freely informed consent to allow the following professional:

Shelley L. Bartel, LSCSW
11100 Ash St., Suite 100
Leawood, KS 66211
(913) 696-1400
(913)696-1403 fax

(X) To furnish information to: __________________________________

(X) To receive information from: ________________________________

The information I am allowing to be released is for the following purpose**: Coordination of mental health care**

I hereby release ***Shelley L. Bartel, LSCSW*** from any liability for information pursuant to this authorization. I understand that my treatment records my include HIV, psychiatric, alcohol or drug abuse information. Treatment records are protected by law and cannot be disclosed without written consent.
I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time. If not previously revoked, this consent will terminate one year from the date signed.

Client Signature:____

Date:____