Authorization to Obtain and Release Information

Client Information

Name: _____ DOB: _____
Gender: _____ SS #: _____
Address: _____ Phone #: _____
_____

I hereby request and authorize: Multicolor Counseling and Consultation, LLC
Luis R. Alvarez-Hernandez, LCSW, CAMS-II
Psychotherapist/Licensed Clinical Social Worker
1 Huntington Road #101, Athens GA 30606 | (404) 585-7665
luisalvarez@therapysecure.com | multicolorwellness.com

To Obtain/Release from/to: Name: _____

Address: _____

_____

Phone: _____

The following type(s) of information:

_____ Psychosocial Assessment or Initial Intake; to include history, current information, diagnosis, and prognosis regarding all of the following areas:

A. Medical/Physical B. Mental Health C. Substance Use
D. Social Work/Case Management E. Family/Social F. Legal or Power of Attorney
G. Other (specify): _____

_____ Individual therapy notes **_____ Group therapy notes**
_____ Date of services only **_____ Consultation regarding presenting problem and current concerns**

For the purpose of: _____

All information I hereby authorize to be obtained and released to and from the above-named entity will be held strictly confidential and cannot be released by the recipient without my written consent. This authorization may include information regarding mental health, substance use, and HIV/AIDS. It also authorizes Mr. Luis R. Alvarez-Hernandez, LCSW, CAMS-II and the above-named entity to verbally discuss my case. I also understand that this authorization will remain in effect unless revoked by me in writing. I understand that it is my right to revoke this authorization in writing at any time.

I authorize the above named entities to correspond regarding my case through the use of:

Postal mail	❑ YES ❑ NO	In Person	❑ YES ❑ NO
Electronic mail (email)	❑YES ❑ NO	Telephone	❑ YES ❑ NO
Facsimile transmittals	❑ YES ❑ NO		

I understand and agree that Mr. Luis R. Alvarez-Hernandez, LCSW, CAMS-II is not liable or responsible for any security risks associated with electronic, email or facsimile correspondence that may be intercepted erroneously by a third party.

This release expires: ❑1 Year ❑ Other: _____

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____
Luis R. Alvarez-Hernandez, LCSW, CAMS-II

Rev. 05/07/2019