Nic Showalter, M.A., LLC
Whole Person Counseling
Authorization to Request and Release Information

I, _____hereby authorize Nic Showalter, M.A., CAC-III to release information to and receive information from the following: (*This release remains in effect one-year from the date of signature.)*

Name: _____ Name: _____

Phone: _____ Phone: _____

Fax #: _____ Fax #: _____

Name: _____ Name: _____

Phone: _____ Phone: _____

Fax #: _____ Fax #: _____

The authorization for release and retrieval of information pertains to the following:
(Please **Initial** by those with an **X** beside them.)

X_____ Evaluation **X**_____ Education

X_____ Treatment **X**_____ Social Services

X_____ Employment **X**_____ Criminal Justice

_____ Other (Explain): _____.

The information to be released includes the following:

X_____ Name **X**_____ Evaluation Results

X_____ Treatment Needs **X**_____ Attendance

_____ Other (Explain): _____.

Signature: _____ Date: _____

Print Name: _____ Date: _____

Witness: _____ Date: _____

Notice to Recipient: *This information was disclosed to you from records whose confidentiality is protected under Federal Law. Federal Regulation (42FR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations: a general authorization for the release of medical or other information is not sufficient for this purpose*