

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 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 | <input type="checkbox"/> YES <input type="checkbox"/> NO | In Person | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Electronic mail (email) | <input type="checkbox"/> YES <input type="checkbox"/> NO | Telephone | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Facsimile transmittals | <input type="checkbox"/> YES <input type="checkbox"/> 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