Autism Clinic and Family Counseling Center
Brad Mason, M.Ed.
LSSP, LPA, LPC

Licensed Specialist in School Psychology
Licensed Psychological Associate
Licensed Professional Counselor
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Confidential: Consent for Release of Information

Client Name: DOB:
SS#:
Address:
Phone:
This consent authorizes Brad Mason, LSSP, LPA, LPC:
_____To release information regarding the above named client to:
_____To gather information regarding the above named client from:

Name:
Organization:
Address:

Phone:
Fax:
____Entire Record _____Assessments _____Progress Notes _____Drug/Alcohol
____Hospital Notes & Discharge Summary _____HIV/Aids
____ Current Medications ____Other:

The purpose of this disclosure/request is:
____Coordination of care ____Treatment planning
____Other :

This consent may be revoked at any time by providing written notice. By signing this form the client acknowledges that they have been given information about what is to be disclosed/requested, the purpose of the disclosure/request, and who will receive the information. Signing this form also releases Brad Mason, LSSP, LPA, LPC from any legal liability resulting from the release of this information. Consent for this disclosure will expire ninety days from the termination of treatment with Brad Mason. This expiration may otherwise be set at the discretion of the client for the following date:

Signature of Client:_________________________ Date:___________
Signature of Therapist:_________________________ Date:___________