351 Wagoner Dr STE 135
Fayetteville, NC 28303
888-550-2804
www.cateRRRflies.com

AUTHORIZATION FOR RELEASE OF INFORMATION

An authorization for release MUST be signed for your insurance company (s). Also please consider if one is needed for your primary care physician and your minor child's physician and school. Print as many copies as needed and upload to the portal.

I (We) authorize Richale R. Reed M.A., LCMHCS, LCAS dba CateRRRflies Lifework

To release and disclose information from the clinical record of:

_____ _____
(Name of Client) (Date of birth)

TO

_____
(Your Primary Care Doctor/Provider)

_____
(Your Primary Care Doctors Address)

Nature of information to be disclosed: PRESENCE IN TREATMENT
(State specific nature of information to be disclosed)

For the purposes of: THE COORDINATION OF CARE FOR THERPUETIC SERVICES
(State specific purpose of information to be disclosed)

This authorization is freely given to Richale R. Reed with the understanding that:

1) any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2) A copy of this release shall have the same force and effect as the original.

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3) I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Richale R. Reed, except where information has already been released. This authorization is valid for one year from the date signed, unless indicated otherwise _____.
(Expiration Date)

4) Richale R Reed MA., LCMHCS, LCAS and employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5) Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6) I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

___ I have read and agree to the terms of this document.

_____ _____ _____ _____
(Client Name 12 yrs. or older) (Date) (Parent/Guardian Name) Optional (Date)