Valerie Lumbley

MA, LPC

RELEASE OF CONFIDENTIAL INFORMATION

I, ____, hereby authorize the release of confidential information between Valerie Lumbley, MS, LPC and:

____

Address ____

Phone_______________________________________ Fax ____

The release includes the following for continuity of care:

__ Psychological Testing

__ Laboratory Testing

__ History and Physical

__ Psychotherapy Notes

__ Physicians Notes

__ Verbal Communication

__ Prescriptions/Medications

__ Psychosocial Assessment

__ Other:_________________________

__ Other:_________________________

Conditions of this release are in effect until the therapist is notified otherwise, in writing by client.

____ ____________________________

Signature of Client/Responsible Party or Guardian Date