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Nancy Newport, LPC, LMFT, PC

Providing psychotherapy to individuals, couples and families

AUTHORIZATION TO RELEASE INFORMATION

I authorize Nancy Newport, LPC, LMFT, PC to exchange professional information with:

Name (discipline) _____

Address _____

_____

Phone number _____

regarding _____, date of birth _____

for the purpose of _____

_____

In consideration of this authorization, I understand that:

1. This is not a required condition of treatment.
2. This authorization is limited to the professionals who are listed above.
3. I may revoke this authorization at any time, and unless it is revoked, it will cease one year from the date it was signed
4. Confidentiality of records and information is protected by federal and state laws. The recipient of this disclosed information is subject to these.
5. I agree to hold harmless and indemnify Nancy Newport, LPC, LMFT, PC, from any and all liability arising from the release of the requested information.

Signed _____

Date _____