423 Weathersby Drive Suite 130, Hattiesburg, MS 39402
601-602-3624 • www.acceptedthearpy.com • acceptedthearpy@gmail.com

I, _____, whose date of birth is _____, authorize Nikki Dear, LCSW of Accepted Therapy Services to disclose and/or obtain information from:_____

The following information (initial each item to be disclosed)

_____ Assessment	_____ Presence/Participation in Treatment
_____ Diagnosis	_____ Progress in treatment
_____ Psychosocial Evaluation	_____ Demographic information
_____ Treatment Plan	_____ Psychotherapy Notes*
_____ Current Treatment Updates	_____ Recommendations
_____ Other: _____	_____ Other: _____

* Psychotherapy note release can not be combined with any other disclosure.

This information may be used or disclosed in connection with mental health treatment or payment. If the purpose is other than as specified above, please specify:

_____

_____

Termination

Unless sooner revoked, this authorization expires 60 days from the termination of my therapy services I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Nikki Dear, LCSW at 423 Weathersby Road Suite 130 or by email to acceptedthearpy@gmail.com. I further understand that revocation will not apply to actions taken by the requesting person/entity prior to the date they receive you written request to revoke authorization.

Conditions

I further understand that Accepted Therapy Services will not condition my treatment on whether I give authorization for the requested disclosure.

_____ _____

Printed Name Signature

_____ _____

Legal Representative Date