I authorize Venue Clinic / Ethan Taylor, LPC to:

☐ **Release information to**
☐ **Obtain information from**
☐ **Exchange information with** (mutual release)

Name/Organization: _____
Address: _____
Phone/Fax: _____

Information to be Released:

(Initial all that apply)

_____ Dates of service and attendance
_____ Diagnosis
_____ Treatment summary
_____ Progress notes
_____ Entire record
_____ Other (specify): _____

Purpose of Disclosure:

(Initial one)

_____ Coordination of care
_____ Legal matter
_____ Personal request
_____ Insurance
_____ Other: _____

Client Rights & Terms of Release

- I understand that I have the right to revoke this authorization at any time by submitting a written request to Venue Clinic, except to the extent that action has already been taken based on it.
- I understand that this release will automatically expire **one year from the date of signature**, unless I indicate otherwise here:
  Alternate expiration date or event (optional): _____
- I understand that information disclosed may be subject to re-disclosure and no longer protected by HIPAA, depending on the recipient.
- I understand that I may refuse to sign this form and that treatment at Venue Clinic is not conditional upon signing.

Patient Signature: _____

Date: _____