Nicole A Schild, LCSW LLC
Release of Information

I, _____, _____, _____
(NAME) (SOCIAL SECURITY NUMBER) (DATE OF BIRTH)

authorize and give this consent voluntarily that information concerning myself or my child be released as outlined below. I have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing this information. I also understand that the provision of services is not contingent on my decision concerning this release of information.

X YES, I WANT INFORMATION RELEASED TO
Nicole A Schild, LCSW LCC
2128 Chamber Center Drive
Ft. Mitchell, KY 41017
FROM:

X YES, I WANT INFORMATION RELEASED FROM
Nicole A Schild, LCSW LLC
2128 Chamber Center Drive
Ft. Mitchell, KY 41017
TO:

TYPE OF INFORMATION TO BE RELEASED:

_____ **Assessment**
_____ **Diagnosis**
_____ **Psychosocial Evaluation**
_____ **Psychological Evaluation**
_____ **Psychiatric Evaluation**
_____ **Treatment Plan or Summary**
_____ **Current Treatment Update**
_____ **Medication Management Information**
_____ **Presence/Participation in Treatment**
_____**Nursing/Medical Information**
____ **Educational Information**
____ **Discharge/Transfer Summary**
____ **Continuing Care Plan**
____ **Progress in Treatment**
____ **Demographic Information**
____ **Psychotherapy Notes***
(*cannot be combined with any other disclosure)
____ **All information**
____ **Other**

EXPIRATION: This release will expire at culmination of treatment unless otherwise indicated:_____

FORM OF DISCLOSURE: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

REDISCLOSURE: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

REVOCATION: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Nicole A. Schild LCSW LLC at 2128 Chamber Center Drive, Fort Michell, KY 41017 or nicki@nicoleschild.com. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

_____ _____
(PRINTED NAME) (DATE)

_____ _____
(Signature of Client/Guardian) (Date)

_____ _____
(Signature of Staff Witness) (Date)