LifeSeasons PSYCHOTHERAPY LLC

13911 Ridgedale Drive, #335
Minnetonka, MN 55305
612.518.8840
fax: 952.546.3000
couragetothrive@gmail.com

Authorization To Disclose Protected Health Information

This authorization for use or disclosure of medical information allows Judith Pinke, MA, LMFT, LifeSeasons Psychotherapy, LLC, to release/exchange *(circle one)* protected information from my clinical record to/with the person(s) I designate.

Client name_____ Date of Birth_____

Client name_____ Date of Birth_____

For the following information about me, I hereby authorize LifeSeasons Psychotherapy, LLC, to **release to** and **receive from**:

- ☐ Ongoing consultation
- ☐ Psychological testing report
- ☐ Relevant case history, diagnosis, treatment plan, termination summary
- ☐ Health Records
- ☐ Progress notes
- ☐ Relevant case history and diagnosis
- ☐ Prognosis
- ☐ Recommendations for future treatment
- ☐ Other
- ☐ _____

Judith Pinke, MA, LMFT — Name: _____

LifeSeasons Psychotherapy, LLC — Organization: _____

13911 Ridgedale Drive, #335 — Address:_____

Minnetonka, MN 55305 — _____

PH. 612.518.8840/Fax 952.546.3000 — Phone: _____ Fax _____

I understand I have the right to:

1. Refuse to release information, sign this authorization, and restrict what is disclosed with this authorization.
2. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
3. Receive a copy of this authorization.

I release my therapist, Judith Pinke, MA, LMFT, and LifeSeasons Psychotherapy, LLC, from any liability arising from the release/exchange of information or records to/with such designated persons or entities. I understand that LifeSeasons Psychotherapy, LLC, cannot condition treatment upon me signing this authorization. LifeSeasons Psychotherapy, LLC, is authorized to disclose the protected health information until _____ or one year from the date of my signature, whichever is shorter.

Client signature:_____ Date: _____

Client signature:_____ Date: _____

Judith Pinke, MA, LMFT _____ Date: _____
LifeSeasons Psychotherapy, LLC