M. Brett Debney, MS, EdS, LPC, NCC

3707-D West Market St
Greensboro, NC 27403
Phone: (336) 686-3555

CONSENT FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I _____, hereby authorize Brett Debney, MS/EdS, LPC, NCC to disclose specific health information from the records of the above named client to:

Name, Address, Phone, Fax

_____

_____

_____

_____

_____

for these specific purpose(s): _____

_____

I agree that this information may pertain to:

- ☐ Assessment and diagnosis
- ☐ Treatment plan
- ☐ Progress notes
- ☐ Treatment summary
- ☐ Billing/Insurance
- ☐ Attendance
- ☐ Other _____

In addition, I authorize the above to release information to Brett Debney, MS/EdS, LPC, NCC. This authorization expires on _____.

I also understand that I may revoke this authorization in writing at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

_____ _____

Signature of Client **Date**

_____ _____

Signature of Personal Representative **Date**