

Ellen R. Hoffman, MA, LPCC, LLC
12417 Cedar Road, Suite 23
Cleveland Heights, Ohio 44106
216-245-7440
ellen@ellenrhoffman.com

Request/Authorization to Release Confidential Records and Information

I hereby authorize:

Person of facility: _____

Address: _____

To release information from records concerning _____

Date of Birth _____;

To the following person or facility: _____

Address: _____

For the purpose of: _____

These records concern the time between _____ and _____

The information to be disclosed includes the following: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Signature of Client

Printed Name

Date

