Megan Orr-Murphy
Authorization to Release Information

Client Name: _____

Purpose: The information received or exchanged may be used to evaluate my situation, to coordinate appropriate services to address my mental health needs, or for other purposes as listed:
_____

I authorize Megan Orr-Murphy, LPC to:

___ Obtain records from
___ Communicate/ share information with
___ Send records to
___ Communicate financial and scheduling info
___ Emergency contact

Name of person/ facility: _____
Address: _____
City/ Sate/ Zip: _____
Phone: _____ Fax: _____

Name of person/ facility: _____
Address: _____
City/ Sate/ Zip: _____
Phone: _____ Fax: _____

Name of person/ facility: _____
Address: _____
City/ Sate/ Zip: _____
Phone: _____ Fax: _____

This permission is good for one year from date of this signature. I understand that I can cancel this at any time, but that cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I certify that I understand the purpose of this agreement and that I choose to sign this agreement.

___ Client ___ Parent ___ Guardian ___ Legal Power of Attorney

_____ _____
Signature Date

_____ _____
Witness Date