kbl scottsdale counseling & consulting

This form when completed and signed by you authorizes Kay Butler-Lueking, LLC, LPC, MC, NCC to release/or request protected health information from your clinical record to the person you designate.

I authorize Kay Butler-Lueking, LLC, LPC, MC, NCC to release/request the following:

CLIENT/PATIENT NAME DATE OF BIRTH

ADDRESS CITY STATE ZIP CODE

PHONE

I authorize Kay Butler-Lueking, LLC, LPC, MC, NCC to release/request the following:

- ☐ Psychotherapy Notes
- ☐ Psychological Exam/Testing Results
- ☐ Thank You For Referral LT/Call
- ☐ Other (specify)
- ☐ Telephone Contact/Consult
- ☐ Treatment Summary
- ☐ Medical Records

NAME

ADDRESS

TELEPHONE FAX EMAIL

This information shall remain in effect until _____or one year from the date signed below. I understand that Kay Butler-Lueking, LLC, LPC, MC, NCC generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a 3rd party.

SIGNATURE DATE