ASCEND
COUNSELING
SERVICES

SHERRY DANIELS, MA, LPC, NCC
2325 W. Shiawassee Ave., Suite 105, Fenton, MI 48430 (810)629-2500 Fax(810)629-2517

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL INFORMATION AND/OR OTHER RECORDS

I, _____
Client's name Date of Birth:

voluntarily and understandingly authorize Sherry Daniels, MA, LPC, at Ascend Counseling Services, 2325 W. Shiawassee Ave, Ste 104,Fenton, Michigan 48430
to release all client, psychological, medical and/or other records of evaluation and/or treatment, of which they are custodian,

to: _____
Name of person/organization to which the disclosure is to be made

2. I understand that unless I expressly direct otherwise, the custodian may release all *relevant requested information* regarding me, including alcohol and drugs abuse, psychology, and social work records, if any.

3. The purpose of such disclosure is as follows:
Reimbursement for behavioral/mental health services

4. I understand that I may revoke this authorization, except to the extent action has already been taken in reliance upon the authorization, at any time by giving written notice to the custodian of the information.

5. If I am signing on behalf of another party (i.e as parent or guardian), I attest by my signature that I have full legal right to so represent that party.

Signed:_____ Dated:_____

Witness:_____