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C0UNSELING AND COMMUNICATION SERVICES
PENNIE J. MCKAY, MA, LCPC, LMFT, NCC
Licensed Clinical Professional Counselor
Licensed Marriage and Family Therapist

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION
TWO WAY

I, _____ hereby authorize: Pennie J. McKay, MA, LCPC, LMFT, NCC
1412 W. Washington St. - Boise, ID 83702 (208)345-1552

To discuss, receive, use, or release information and records during the course of treatment of:
Client Name: _____ Date of Birth: _____
Address: _____ Client's Phone #: _____
_____

1. The information is to be used or disclosed to/from the following persons or organizations:
   Person/Entity Name: _____
   Address: _____
   Phone & Fax: _____

2. Purpose: The purpose of the use or disclosure:
   ~ At the request of the client
   ~ Other: _____

3. The information to be used or disclosed includes all reports, observations, and impressions for the time the previously stated parties were/are involved with me and/or my child.

   Understanding that I am signing this release of my own free will I release Ms. McKay from all legal responsibilities or liability that may arise from the use of disclosure of my records or other health information *in reliance on this authorization.*

   If client is a minor, relevant state law should be followed. **Adolescents over the age of 14 must sign authorization, in addition to their parent and/or guardian.**
   1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire in 180 days, or according to the relevant state law, from the date this authorization is signed.
   2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or re-disclosed by the receiving party.
   3. **Refusal to sign:** I understand that I may refuse to sign this authorization.
   4. **Certification:** I certify that I am (check which ever applies):
      ____The client, and the identification that I have provided is true and correct.
      ____The client's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the client is that of:_____.
   5. **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
   6. **Copy:** I understand I may receive a copy of this complete form.

_____ _____
Client's Signature Date Parent/Guardian's Signature Date

_____
Witness' Signature Date