Mary M. Landon, PhD, LPC
Licensed Professional Counselor

Balanced Life Counseling

Authorization to Release Protected Health Information (PHI)

I (Client's name) _____ (Date of Birth) _____ give permission to Dr. Mary Landon of Balanced Life Counseling to send and/or discuss confidential case records and/or test results, to send treatment summaries and diagnosis information to, and to receive confidential information from my primary care physician or other desired person or entity:

Name:_____

Address:_____

_____

Phone: _____ Fax:_____

I understand my service record is protected under Federal and State regulations and that information to be released by my signature may contain information pertaining to medical, psychiatric, substance abuse treatment, and/or confidential HIV/AIDS related information.

This consent shall be in effect from _____ until _____. (No longer than one year)

_____ Date:_____
Signature of Client

_____ Date:_____
Signature of Therapist
Mary M. Landon, PhD, LPC

3919 Old Lee Highway Suite 82C
Fairfax, VA 22030
(202) 760-1998

www.BalancedLifeCounseling.net
Mary.Landon@BalancedLifeCounseling.net