



Teresa R. Weis, LPC, LMFT  
Insights Outside, LLC  
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**Authorization to Release/Receive Confidential Information**

Client Name \_\_\_\_\_ Birth Date \_\_\_\_\_

I authorize Teresa Weis to:

(Please initial all that apply)

- receive information from:
- release information to:

Person and/or Agency \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

This information is needed for the following purpose(s): (please initial all that apply)

- Mental health treatment, planning, consultation and continuity of care
- Diagnosis and assessment
- Other \_\_\_\_\_

The information to be disclosed includes the following: (please initial all that apply)

- Information about past/current treatment
- Assessment/Testing
- Consultation
- Physical health/medical information
- Treatment Summary
- Medications in Treatment
- Treatment goals, progress and results
- Alcohol and Drug Treatment Information
- AIDS/HIV
- Other

I understand that my records are protected under the federal HIPPA and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that Teresa Weis MA, MFT cannot guarantee that the recipients of this information will not re-disclose my health information to another party. I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it.

This authorization shall remain in effect until \_\_\_\_\_ or until 30 days after termination of counseling services with Teresa Weis, LPC, LMFT.

Client Name \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian/Legal Representative (required if client is under 18 or not competent to sign) Date

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_