RON LEONARD, PCC
19126 RAVENNA ROAD
AUBURN TOWNSHIP, OH 44023
PHONE: 440-781-7323

AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

FROM THE CLIENT RECORDS OF:

NAME: _____DATE: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

PHONE: (_____)_____ DATE OF BIRTH: _____SSN: _____

I AUTHORIZE RON LEONARD, PCC TO:
RELEASE TO ☐ OBTAIN FROM ☐

Facility/Individual: _____

Address:
_____STATE_____ZIP_____

I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION, WHICH MAY INCLUDE, THE DIAGNOSIS AND TREATMENT OF MENTAL AND EMOTIONAL DISORDERS:

☐ Summary of Treatment (including diagnosis, number of sessions attended and progress)

☐ Other_____

DATES OF TREATMENT: _____ RELEASE FORMAT: ☐ Verbal ☐ Written

PURPOSE OR NEED FOR INFORMATION: _____

DATE AUTHORIZATION EXPIRES: _____
(Date or specific action)

_____
CLIENT NAME - PRINT

_____ _____
CLIENT SIGNATURE Date Witness Signature
Date

_____
Personal Representative Date Relationship (Guardian, parent, durable power of attorney)

If the person that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person and will likely no longer be protected by the federal privacy regulations.

REVOCATION This authorization can be revoked by the client named above, or his/her guardian, parent, or durable power of attorney at any time, except to the extent that action has been taken by Ron Leonard, PCC in reliance on this authorization, by sending a written revocation request to RON LEONARD, PCC, 8235 Memphis Avenue, Brooklyn, OH 44023