

Sterlingworth Center  
Mary Blair Dellinger, LPC, BCN  
Licensed Professional Counselor (#7808), State of South Carolina  
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**Authorization for Release/Exchange of Information**

I, \_\_\_\_\_, authorize Mary Blair Dellinger to disclose/exchange the following types of private information pertaining to the undersigned client:

Information to be Released/Exchanged: (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Intake & History               | <input type="checkbox"/> Treatment Progress        |
| <input type="checkbox"/> Diagnosis & Treatment Plan     | <input type="checkbox"/> Discharge Summary         |
| <input type="checkbox"/> Written Report & QEEG Findings | <input type="checkbox"/> Billing & Payment         |
| <input type="checkbox"/> Other (specify): _____         | <input type="checkbox"/> Evaluation & Test Results |

Purpose for Release/Exchange of Information: (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Administration/Academic Coordination | <input type="checkbox"/> Medical Care                    |
| <input type="checkbox"/> Coordination of Care/Treatment       | <input type="checkbox"/> Guardian/Familial Communication |
| <input type="checkbox"/> Personal                             | <input type="checkbox"/> Other: _____                    |

This release shall be valid until the termination of treatment or until withdrawn in writing by the client during the course of treatment. The undersigned acknowledges and reserves the right to: (a) revoke this authorization at any time by notifying Ms. Dellinger in writing (Such notification, however, will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation.); (b) inspect or request a copy of the information to be used or disclosed as consistent with Federal law; and (c) receive a copy of this signed authorization.

I hereby authorize the disclosure of the personal information as described above to (Name/Relation, Address, and Phone):

- (1) \_\_\_\_\_  
\_\_\_\_\_
- (2) \_\_\_\_\_  
\_\_\_\_\_
- (3) \_\_\_\_\_  
\_\_\_\_\_

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that if the individual or organization authorized to receive this information is not a health care plan or health care provider the released information may not be protected by Federal HIPAA privacy regulations, and, therefore, may not be subject to re-disclosure laws. I also understand that my report(s) may contain information concerning psychological impairment, drug or alcohol abuse and/or other sensitive personal information.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Client Name: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_

Client or Client's Personal Representative: \_\_\_\_\_  
(Signature)