Suzanne LeMere Guerin, Ed.S., M.Ed., LPCA
Counseling and Psychotherapy
7000 Houston Road, Building 200, Suite 15
Florence, KY 41042
859-816-4998

AUTHORIZATION FOR RELEASE OF INFORMATION

Client_____

Client's Address_____

Client's Date of Birth_____

This will authorize Suzanne LeMere Guerin, Ed.S., M.Ed., LPCA

to release to_____

the following:

_____ Documentation that I am/was a client of Suzanne LeMere Guerin, Ed.S., M.Ed., LPCA

_____ Documentation that I am receiving/did receive counseling services from Suzanne LeMere Guerin, Ed.S., M.Ed, LPCA.

_____ Information from the medical/case record maintained while I am/was a client of Suzanne LeMere Guerin, Ed.S., M.Ed., LPCA.

I certify, with my signature below, that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Authorization for Release of Information and the release of confidentiality referenced therein.

I release and hold harmless Suzanne LeMere Guerin, Ed.S., M.Ed., LPCA from any action or liability arising out of my participation in treatment.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date