3719 Latrobe Drive, Suite 850, Charlotte, NC 28211
11600 North Community House Road, Suite 125, Charlotte, NC 28277
Phone: (704) 927-5885 Fax: (866) 372-5885

AUTHORIZATION TO RELEASE INFORMATION

From Transformative Life Center

I, **(name of patient)** _____, (hereinafter "Patient") hereby authorize Dr. Rose LeDay of Transformative Life Center, LLC. (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychological evaluation and /or psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at **11600 North Community House Road, Suite 125, Charlotte, NC. 28277** to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose: treatment planning and care coordination.
The specific uses and limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to)**: Information derived from interview, testing and psychological evaluation.

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable North Carolina law may protect such information.

This authorization shall remain valid until: _____

Patient's signature: _____ Date:_____