Healing Steps Family Therapy, LLC
Stephen M. Stepanovich MS, MFTIntern
3127 E. Warm Springs Rd. Suite 300
Las Vegas, NV 89120
healingstepsfamilytherapy@gmail.com

AUTHORIZATION
To Release Confidential Information

Client Name: ____ **Date of Birth:** ___________________

I hereby authorize a representative of Healing Steps Family Therapy, LLC to contact the agency or person specifically listed on this form to exchange such information for the purpose of providing assessment, case management, and/or treatment services for the client named above.

Agency or person to whom a representative of Healing Steps Family Therapy, LLC is authorized to release information:

Name: ____

Address: ____

City: ______________________________ State: ________________ Zip Code: ___________________

Telephone Number: ____

Records to be Released: ____

I understand that my records are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on my consent, and that in any event this consent expires automatically on the date stated below or upon termination of services for which the consent was granted, whichever comes first.

Date of expiration: ____
Person(s) signing authorization:

______________________________ ______________________________ ________________
Client or Guardian **(please print)** Signature Date

______________________________ ______________________________ ________________
Client or Guardian **(please print)** Signature Date

Witness:

______________________________ ______________________________ ________________
Name **(please print)** Signature Date