RELEASE OF INFORMATION FORM

Client Information

Today's Date _____ / _____ / _____

Client Name _____ DOB ____ / ____ / _____/_____
First & Last Name (Please print) Age

I authorize **Bevill and Associates, LLC** to :

_____ Provide to: _____ Receive from:

Facility/Person:_____ _____
Phone Number

Address _____ _____ _____
Street City State Zip Code

Information to be provided by
Bevill and Associates, LLC.

___Individual Assessment
___Treatment Summary
___Telephone Consultation
___Test Results
Other _____

Information requested by
Bevill and Associates, LLC

____Individual Assessments
____Treatment Summary
____Telephone Consultation
___Test Results
Other _____

This information is being disclosed to the above identified parties from records whose confidentiality is protected by federal law. This authorization is effective for 12 months and may be terminated at any time, except to the extent that the program, which is to make the disclosure, has already acted in reliance upon it.

I hereby release the named parties [requesting and receiving information] from all legal liability that might arise from the release of the information requested.
I consider a photocopy of this authorization to be as valid as the original.
By signing below, I agree to this release of information request.

_____ _____ _____
Client's Printed Name Client's (or Responsible Party's) Signature Date

_____ _____
Therapist Signature Date

Bevill and Associates LLC
2070 Valleydale Road Suite 7
Birmingham, AL 35244

Bevill and Associates LLC
2070 Valleydale Road Suite 7
Birmingham, AL 35244