NMK, LCPC & Associates

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Consent For Release Of Information

I authorize **NMK, LCPC & Associates and Rendering Provider(s):**

_____ and the person(s) listed below to communicate with each other by phone, email/text, written document, or in person:

_____

(Name of facility, physician, practitioner, or other: please specify)

_____
(Email, Telephone, and/or address)

_____

Information may be released regarding:

_____

_____

_____

About: _____

(Client/Patient's name and Date of Birth)

To gain further insight, provide excellent client care, and aid in treatment planning.

I understand that I may revoke this consent at any time and that I have the right to inspect and copy the information to be disclosed.

A. _____
(Client/Patient)

B. _____
(Parent or Guardian, if Minor)

Date _____

4/2025 last updated