

*Victoria L. Steele MC*

Licensed Professional Counselor  
130 W. River Road, Tucson, AZ 85704  
520-401-0935 [victoria@counselorvictoriasteel.com](mailto:victoria@counselorvictoriasteel.com)  
[www.counselorvictoriasteel.com](http://www.counselorvictoriasteel.com)

**Consent to Disclosure of Information and Records**

I, \_\_\_\_\_ (Date of Birth: \_\_\_\_\_) hereby authorize Victoria L. Steele, MC LPC to release my records and reports relating to my appointments beginning with my first appointment on \_\_\_\_\_. This information is to be given to: \_\_\_\_\_; for the following purpose, use or need:

- Coordination of treatment
- Provision of information to other professionals
- Other \_\_\_\_\_

The following information from my records may be disclosed:

- General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
- Psychotherapy Notes
- Verbal Exchange of PHI

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until six (6) months from date of signature.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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**Consent By Person Other Than Client**

If client is under 18 years of age or otherwise unable to consent, the following must be completed:

I, \_\_\_\_\_ hereby certify that I am the \_\_\_\_\_ of the client; that the client is unable to consent because he/she is a minor, \_\_\_\_\_ years of age or because:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent, Guardian, etc.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date