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**AUTHORIZATION FOR RELEASE and/or EXCHANGE OF INFORMATION for the  
Emergency Contact in Cases of Emergency**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Maiden/Given Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_

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IN 46383

I request and authorize \_\_\_\_\_  
to release and/or exchange information to:

Emergency Contact  
Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization will be used for the purpose of:

Scheduling, information gathering, treatment verification, treatment, diagnosis, and  
cases of emergencies.

and is confined to the following *specified* and *initialed* information: Scheduling \_\_\_\_\_, information gathering \_\_\_\_\_,  
treatment verification \_\_\_\_\_, treatment \_\_\_\_\_, diagnosis \_\_\_\_\_,

Other: \_\_\_\_\_

THIS AUTHORIZATION IS VALID UNTIL: \_\_\_\_\_

(must have date within next 12 months)

I understand that I may revoke this authorization at any time, but not retroactive to the release of  
information made in good faith, by writing to the above specified parties. I understand that information  
released by this authorization may be subject to re-disclosure by the recipient and may no longer be  
protected by Federal Law. It has been explained to me that if I decline to consent to this release of  
information, the following are the consequences: Specify (if any):

\_\_\_\_\_  
Signature of Person Authorizing \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Client \_\_\_\_\_

**NOTE: Authorization must be filled out in its entirety in order to be valid. NOTICE TO RECEIVING AGENCY/PERSON:  
You may not redisclose any of this information unless the person who consented to this disclosure specifically  
consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug abuse Patient  
Records, neither such records, nor information from such records may be further disclosed without specific  
authorization for such disclosure.**