

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize _____ on _____
(Name of Client) (Name of Therapist) (Date)

Mark appropriate response:

- To disclose
- To exchange with
- Receive the following information from

Institution, Agency, Person:

Name _____
Address _____
City, State, Zip _____
Phone (_____) _____ - _____

Information Requested (mark appropriate boxes)

- | | | |
|--|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Substance Abuse Records |
| <input type="checkbox"/> Chart Notes | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Summary of Progress |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Outpatient Records | <input type="checkbox"/> Termination Summary |
| <input type="checkbox"/> Court Hearing Records | <input type="checkbox"/> Psychiatric Admit Note | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Crises Response Reports | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Urinalysis |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Psychological Report | |
| <input type="checkbox"/> Inpatient Records | <input type="checkbox"/> Psychosocial Assessment | |

Other information (specify) _____

Purpose (specify reason for disclosure) _____

I understand that I may cancel this consent at any time. Unless earlier canceled, this consent shall expire on the specified date or a maximum of ninety (90) days from the date of signing. Specify date, event or condition upon which this consent expires.

Signature of Client (If client is 13 years of age or older, he/she must sign consent) Date of Birth _____ Date Signed _____

Signature of Parent/Guardian (for minors) Date Signed _____

Signature of Witness/Therapist Date Signed _____

Cia Flodin, M.Ed. LMHC, keeps a record of the services she provides you. You may ask to see and copy that record. You may also ask for a correction to that record. She will not disclose your record to others unless you direct her to do so or the law authorizes or compels her to do so. This authorization conforms to State and Federal Regulations. Records obtained as authorized by this consent for information release will be maintained in accordance with Federal confidentiality regulations, which prohibit further disclosure without written consent of the person to whom it pertains or otherwise permitted.