Consent for Release & Receipt of Information

Today's Date_____

I hereby authorize _____ located at the above address to RELEASE & RECEIVE information from the
Name of Therapist

records of _____ _____ . **Name of Client Date of Birth**

I authorize the following information to be released:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment
- ☐ Update Medication
- ☐ Management
- ☐ Participation in Treatment
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Continuing Care Plan
- ☐ Treatment Progress
- ☐ Psychotherapy Notes*
- ☐ Other _____

I authorize the above information to be released to/received from:

_____ _____ _____

Name of Individual(s) or Organization(s) Phone /Far Email

_____

Address City State Zip

I understand that this consent will expire upon my termination of treatment with _____
Name of Therapist

I have the right to change my mind regarding the release/receipt of information from my clinical record at any time, unless such information has already been released/received. The undersigned understands the nature of the authorization and has informed that she/he has the right to revoke the consent at any time.

_____ _____
Client/Parent/Legal Guardian/Authorized Representative Date

_____ _____
Signature of Client age 14 to 18 Date

NOTE to recipient of this information: This information has been disclosed to you from records whose confidentiality Is protected by Federal & State Law whose regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. Anyone who receives information covered by these regulations, whether obtained legally or not, is prohibited from using that information for any criminal or civil investigation, or prosecution of the patient.