CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Client Name___________________________

Provider Name_________________________

Persons, Agencies or Providers to whom discloser is to be made_________________________

Address____

Phone Number________________Fax Number______________________

For Purpose of (check all that apply):

☐ Receiving information to benefit and inform:
  - Treatment Planning
  - Psychological Evaluation
  - Educational Planning

☐ Disclosing:
  - Testing Results and Recommendations
  - Testing Report
  - Treatment Impressions
  - Treatment Summary
  - Treatment Record

Only information directly relevant to the purpose of the communication will be disclosed.

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for discloser of confidential healthcare records or information. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom discloser was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This consent expires within 60 days (date) ____________________________

____ ________
Signature of client (or person acting for client) Date

__________________________________ ________________________________
Printed name Relationship to client (if necessary)