

Stone Creek Psychotherapy and Wellness Center

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize _____,
Client/Parent/Guardian Therapist's Name
(if a minor) regarding, _____.

Mark the one(s) that apply to you:

- To disclose and discuss clinical and treatment information with, _____, or _____.
Other Mental Health Provider's Name Attorney/Law Firm
- To exchange clinical information, such as diagnosis, treatment goals, and medication issues with my Physician, _____, for the
Physician's Name
purpose of treatment planning and coordination.
Contact phone number and address:

- To disclose and discuss clinical and treatment information with, _____ and/or _____.
School Name Counselor /Teacher

- To disclose and discuss clinical and treatment information with, _____ please explain:
Other

- I prefer that no clinical and/or medical information be released at this time.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 90 days after the date signed unless another date is specified. Specification of the date, event or condition upon which consent expires:
_____.

Client Name (Please print)

Witness

Client or Guardian's Signature

Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is Protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it with the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.