ASSOCIATED PSYCHOTHERAPISTS

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize _____, to
(Client's Name) (Therapist's Name)

___ Obtain information from AND/OR ___ Disclose information to

Name and address: _____
_____
_____

The following information:

___ Diagnosis
___ Progress notes
___ Prognosis
___ Drug/Alcohol History
___ Mental Status Exam
___ Treatment Summary
___ Recommendations
___ Other records as specified:
_____

The purpose for such disclosure is:

___ Continuity of Care
___ Contact with
___ Family Involvement
___ Referral
___ Other

This consent is subject to revocation at any time except to the extent that action has been taken in reliance upon it. If not previously revoked, this consent will terminate upon this date: _____.

_____ _____
Signature of client Date

_____ _____
Signature of parent, guardian or authorized Representative (when required) Date

_____ _____
Signature of witness Date