

CONSENT FOR RELEASE/REQUEST OF CONFIDENTIAL INFORMATION

Patient Name:	DOB:
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I give permission to disclose my health and mental health care information between:

- | | | |
|--|---|---|
| <input type="checkbox"/> Robert Arnio, Ph.D | <input type="checkbox"/> Marvin Bouska, M.S. | <input type="checkbox"/> Margaret Kelsey (Carver-Grupp), Ph.D |
| <input type="checkbox"/> Jennifer Kozel, Ph.D, LCP, Inc. | <input type="checkbox"/> Stacy Keyser, LPC-MH | <input type="checkbox"/> Trisha T Miller, Ph.D, Inc. |
| <input type="checkbox"/> Lisa Porisch, LPC-MH, Inc., RPT-S | <input type="checkbox"/> Mark Perrenoud, Ph.D, Inc. | <input type="checkbox"/> Lynette Quast, Ph.D |
| <input type="checkbox"/> Al Lloyd, LPC-MH, RPT | | |

AND

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED (includes verbal exchange)

- | | |
|---|--|
| <input type="checkbox"/> Intake Summaries | <input type="checkbox"/> Behavior Checklists |
| <input type="checkbox"/> Psychological Evaluation Results | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Diagnosis Only |
| <input type="checkbox"/> Treatment Summaries | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Communications (To Include: Verbal, Written, Fax, Email, Electronic, etc.) | |

Check if ONLY allowing verbal exchange of information between parties above.

Purpose of Disclosure	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Legal Purposes	<input type="checkbox"/> Coordinate Services	<input type="checkbox"/> Other
Expiration Date	This authorization will expire one year from the date of signature or _____			
Revocation	I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization.			
Authorization	<ol style="list-style-type: none"> 1. I authorize the above facility to disclose information as noted above. 2. I understand it is possible that sensitive information such as alcohol and drug usage may be released. 3. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. 4. I understand that this authorization is voluntary and I may refuse to sign. 5. I also understand that unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits. 6. I understand that the exchange of information may include electronic transmissions. Specify Exceptions:			

Patient <i>(if 18 years of age or older)</i> or Legal Guardian (sign)	Date	Print Name (include legal guardian name if signing for Patient/ Person/Student
Relationship to Patient/Person/Student		

****A PHOTOCOPY OR FAX OF THIS AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS THE ORIGINAL**