CONSENT FOR RELEASE/REQUEST OF CONFIDENTIAL INFORMATION

Patient Name:	DOB:

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

__Robert Arnio, Ph.D
__Jennifer Kozel, Ph.D, LCP, Inc.
__Lisa Porisch, LPC-MH, Inc., RPT-S
__ Al Lloyd, LPC-MH, RPT
__Marvin Bouska, M.S.
__Stacy Keyser, LPC-MH
__Mark Perrenoud, Ph.D, Inc.
__Margaret Kelsey (Carver-Grupp), Ph.D
__Trisha T Miller, Ph.D, Inc.
__Lynette Quast, Ph.D

AND

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED (includes verbal exchange)

( ) Intake Summaries
( ) Psychological Evaluation Results
( ) Therapy Notes
( ) Treatment Summaries
( ) Communications (To Include: Verbal, Written, Fax, Email, Electronic, etc.)
( ) Behavior Checklists
( ) Treatment Plans
( ) Diagnosis Only
( ) Other _____

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

Purpose of Disclosure	**( ) Diagnosis**	**( ) Legal Purposes**	**( ) Coordinate Services**	**( )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	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 (***if 18 years of age or older***) or Legal Guardian (sign)

Date

Print Name (include legal guardian name if signing for Patient/ Person/Student

_____

Relationship to Patient/Person/Student

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

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