Juanita Mitchell, LMHC, CPT

4317 E. Genesee Street ♦ Suite 105 ♦ Syracuse, NY 13214 ♦ (315)569-1968

Release of Information Consent

Name of Client:_____DOB: _____
Address: _____ City: _____ State: _____ Zip: _____

I understand that the purpose of this release is to assist with my/this client's treatment by improving communication between professional service providers/agencies and the important individual(s) in my/the client's life. I have been informed of the risks to privacy and limitations on confidentiality with the use of electronic means of information transfer, and I accept these.

I, client/parent/guardian (circle) authorize Juanita Mitchell, LMHC to:

_____ (send) ____ (receive) the following information ____ (to) ____ (from)

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

The information to be disclosed is marked below.

____ Name of therapist ____ Attendance ____ Progress in treatment
____ Discharge plans/summary ____ Treatment plan ____ Treatment summary
____ Compliance with treatment ____ Psychological evaluation
____ Medical reports ____ Medications
____ Other (specify) _____

The purpose or need for such disclosure of information is/are for the following purposes:

____ Coordination of treatment _____ Continuing appropriate treatment
____ Confirmation of attendance _____ Confirmation of progress
____ Referral _____ Case review
____ Legal concerns
____ Other (specify) _____

I understand that the confidentiality of my records will be protected by applicable State and Federal Laws and regulations. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I also understand that this authorization is voluntary, I may refuse to sign this authorization, receive a copy of this, or revoke this consent at any time, except to the extent that it has already been acted upon. This consent unless revoked earlier **in writing** expires:

____ When I am no longer receiving services from Juanita Mitchell, LMHC.
____ One year from this date ____ 90 Days following treatment
____ Upon completion of treatment ____ Other_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: _____/____/_____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: _____/____/_____