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## Consent to Release Confidential Information

**Client Name:**

**DOB:**

**SSN:**

**Phone:**

**Address:**

**City, State, Zip:**

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I, \_\_\_\_\_, hereby authorize the release and exchange of information specified below between:

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Name/Title or Organization Name (i.e., Psychiatrist/Primary Care Physician/Attorney)

Clinic/firm Name

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Organization/Address

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Phone/Fax

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and

Jesse Sparks LMHC, NCC  
P: 407.325.5521 | F: 407-645-1017

This release of information shall be limited to the following specific types of information:

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|--|--|
| <input type="checkbox"/> Assessment                          | <input type="checkbox"/> Nursing/Medical Information       |
| <input type="checkbox"/> Diagnosis                           | <input type="checkbox"/> Toxicological Reports/Drug Screen |
| <input type="checkbox"/> Psychosocial Evaluation             | <input type="checkbox"/> Educational Information           |
| <input type="checkbox"/> Psychological Evaluation            | <input type="checkbox"/> Discharge/Transfer Summary        |
| <input type="checkbox"/> Psychiatric Evaluation              | <input type="checkbox"/> Continuing Care Plan              |
| <input type="checkbox"/> Treatment Plan or Summary           | <input type="checkbox"/> Progress in Treatment/Notes       |
| <input type="checkbox"/> Current Treatment Update            | <input type="checkbox"/> Demographic Information           |
| <input type="checkbox"/> Medication Management Information   | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Other _____                       |

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: \_\_\_\_\_

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Rachel Eddins in writing. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless expressly permitted by the patient or someone authorized to act on his/her behalf. I understand that this authorization authorizes the release of all medical records including Psychiatric, Alcohol, Drug Abuse, and AIDS records.

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Client Name (Printed)

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Client Signature

Date