CONSENT TO RELEASE RECORDS

CLIENT NAME(S): _____ DOB: _____

Address: _____ City: _____ State: _____ Zip _____

Phone: _____

This consent authorizes Sarah Reidy, LCSW, SEP to:

___ release information regarding the above named client to:

___ receive information regarding the above named client from:

NAME: _____

Organization:_____

Address: _____ City: _____State: _____ Zip _____

Phone: _____ Fax: _____

Email: _____

The information below will be disclosed/requested:

____ Entire Record
____ Initial Assessments & Final Diagnoses
____ Psychotherapy Notes
____ Dates/times/attendance at appointments, general themes, and contact information
____ Other: _____

The purpose of this disclosure/request is:

___ Coordination of Care ____ Treatment Plan

___ Other _____

This consent may be revoked at any time by providing written notice. By signing this form, the client acknowledges that s/he has been given information about what is to be disclosed/requested, the purpose of this disclosure/request, and who will receive this information. Signing of this form by the patient also releases Sarah Reidy, LCSW, SEP from any legal liability resulting from the release of this information. Consent to this disclosure will expire in eighteen months from the date signed unless otherwise designated below.

Client Signature Date

Sarah Reidy, LCSW, SEP Signature Date