Hope for Healing Counseling, LLC 11225 N 28th Drive, Suite A210, Phoenix, AZ 85029

Phone: 602-883-3646 Fax: 602-491-2119

**CONSENT TO RELEASE**

**PSYCHIATRIC / MEDICAL and/or ALCOHOL / DRUG ABUSE**

**RECORDS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_,

hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to have bilateral exchange of information that is contained in my medical record with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

under the conditions listed below:

 1. This information will be limited to:

 \_\_\_\_ Psychiatric/medical/alcohol/drug abuse evaluation.

 \_\_\_\_ Psychiatric/medical/alcohol/drug abuse discharge

 summary.

 \_\_\_\_ Progress notes. \_\_\_\_Psychological testing.

 \_\_\_\_ Psychotherapy notes. \_\_\_\_Educational testing.

 \_\_\_\_ Lab studies. \_\_\_\_Other:

 \_\_\_\_ Medical tests/studies. \_\_\_\_Other:

 2. Purpose or need for such disclosure: \_\_\_\_\_\_ Continuing care/ Treatment, and/or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon \_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Specific Date, Event or Condition)

1. An additional consent must be obtained for any other transfer or disclosure of this information.

5. I understand that I may receive a copy of this release.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent, Guardian or other Person Date

authorized by law to sign in lieu of Patient

(where required). Indicate which.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (if applicable) Date

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