ART OF THE HEART
COUNSELING SERVICES LLC

CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Client's Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

I hereby authorize the following party (who you are requesting the information from):

Name: _____

Address: _____

Phone/Fax/Email: _____

to release to and/or exchange information with (who you want to release the information to):

Name: _____

Address: _____

Phone/Fax/Email: _____

The purpose of this release is for:

_____ Continuity of care
_____ Coordination of care with another treating healthcare provider
_____ Coordination of care with the client's school to meet the client's educational needs
_____ Insurance plan or third-party-payer review of records for quality and level of care and/or justification of charges, and as needed to authorize more sessions or to process claims, or to fulfill administrative review by plan
_____ Other: _____

The information released will be limited to:

_____ Attendance
_____ Summary of pertinent psychiatric and psychosocial history
_____ Treatment Summary
_____ Complete mental health assessment and treatment records
_____ Any information (educational, medical, court-related, etc.) deemed necessary to coordinate care
_____ Other: _____

The requesting party certifies that information will not be used for any other purpose than its intended use and will not be re-released to another party. The client understands that s/he has the right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon. If not revoked earlier, this consent expires 3 years from this date.

SIGNATURE: _____ PRINTED NAME: _____ DATE: _____

SECOND PARTY SIGNATURE: _____ PRINTED NAME: _____ DATE: _____