Consent for Release of Confidential Patient Information

Lisa Hayes, M.S., Licensed Marriage and Family Therapist, MFC #48886
161 Fashion Lane, Suite 110, Tustin, CA 92780 (949) 829-3397

This consent authorizes: _____
(Individual Releasing Information)

_____ _____
(Address) *(Phone Number)*

To release the following information on: _____
(Client Name)

To: _____
(Individual Releasing Information)

_____ _____
(Address) *(Phone Number)*

For the purpose of: ____ Insurance Claim ____ Continuity of Care
_____ Coordination of Services _____ Other _____

The information to be disclosed is as follows (please check all those applicable):

____ Admission / Discharge Summaries
____ Medical History / Physical Exam
____ Psychological Evaluation / Testing
____ Therapy Attendance Record
____ Medication Evaluation and Diagnosis
____ Treatment Plan
____ Psychiatric Evaluation / History
____ Other _____

I understand that I may request in writing to rescind this agreement at any time and that I have the right to receive a copy of this authorization upon request. A photocopy/fax of this Consent to Release Information is as valid as the original. This consent is due to expire (check one):

____90 Days from Date Signed **___ Date of Termination/Discharge from Therapy**

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed written consent of the client and/or parent (or authorized representative) is prohibited. These records may be protected by the Federal Regulation (42 CFR part 2).

_____ _____
Signature of Client, Parent or Legal Guardian Date Signed

_____ _____
Printed Name of Client, Parent or Legal Guardian Date Signed

_____ _____
Therapist's Signature Date Signed

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