COUNSELING CONNECTIONS

Psychiatry, Psychology & Social Work
A Therapeutic Coalition

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Jennifer Underwood, L.C.S.W.

Michael Greenbaum, M.D.

Shazia Tayyab, M.D.

RE: _____

I authorize and request Counseling Connection to release confidential protected health information including personal, psychiatric, medical, laboratory, psychological testing and interpretation, social, educational, substance abuse, clinical information and opinions regarding myself and/or

_____, as well as the re-release of the following information _____

_____ TO:

Name: _____
Address: _____
City, State, Zip: _____

who likewise is authorized and requested to release all said information to Counseling Connection. This authorization will be valid for 12 months from the date of signing and limited to only that information that I have requested above to be released to the person named herein. The purpose of the release of information is to assist in providing complete care. All information released can be inspected and copied by the client. It is understood that I have the right to revoke the consent contained herein at any time during its validity.

I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such material to the person named herein, with the potential consequence of reduced accuracy and completeness of my care.

_____ _____

Signature of patient (if over 12 years) | Signature of Parent/Guardian (if under 18 years)

_____ _____

Date | Signature of Witness

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COUNSELING CONNECTIONS

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AUTHORIZATION TO RELEASE INFORMATION
PSYCHOTHERAPY NOTES

RE: _____

I authorize and request Counseling Connection to release psychotherapy notes (which is a part of protected health information) regarding myself and/or _____, as well as the re-release of the following information _____ _____ TO:

Name: _____

Address: _____

City, State, Zip: _____

who likewise is authorized and requested to release all said information to Counseling Connection. This authorization will be valid for 12 months from the date of signing and limited to only that information that I have requested above to be released to the person named herein. The purpose of the release of information is to assist in providing complete care. All information released can be inspected and copied by the client. It is understood that I have the right to revoke the consent contained herein at any time during its validity.

I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such material to the person named herein, with the potential consequence of reduced accuracy and completeness of my care.

_____ _____
Signature of patient (if over 12 years) Signature of Parent/Guardian (if under 18 years)

_____ _____
Date Signature of Witness

C:\Documents and Settings\Administrator\My Documents\counseling connection administration\Release of Info. psychotherapy notes.DOC

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