EAST LOUISVILLE PSYCHOLOGY GROUP, PLLC

Consent to Release/Obtain Protected Health Information

I hereby authorize **Dr.** ____________________to release/obtain confidential records concerning:

Client Name _________________________ **Date of Birth**__________________

This information may be released to, or obtained from:

____
Name of Person or Agency

____
Address of Person or Agency

____
Phone Fax Email

The purposes of this exchange of information are:

[ ] Further Mental Health Evaluation, Treatment, or Care
[ ] Treatment Planning
[ ] Other ____________________

The following types of information may be shared:

[ ] Treatment Updates/Treatment Planning
[ ] Intake & Discharge Summaries
[ ] Developmental/Social History
[ ] Progress Notes
[ ] Other ____________________

This consent has been explained to me and I fully understand this consent to release records and/or information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may withdraw this consent at any time by notifying my provider in writing. I acknowledge that any action already taken based upon this consent cannot be rescinded. This consent expires ________________________

_____________________________________ ___________________
Signature of Client or Parent/Guardian Date

____________________________________ ___________________
Printed Name of Client Relationship to Client