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CONSENT TO RELEASE RECORDS

CLIENT NAME(S): _____ DOB: _____
Address: _____ City: _____ State: _____ Zip _____
Phone: _____

This consent authorizes Sarah Reidy, LCSW, SEP to:

___ release information regarding the above named client to:
___ receive information regarding the above named client from:

NAME: _____
Organization: _____
Address: _____ City: _____ State: _____ Zip _____
Phone: _____ Fax: _____
Email: _____

The information below will be disclosed/requested:

___ Entire Record
___ Initial Assessments & Final Diagnoses
___ Psychotherapy Notes
___ History
___ Other: _____

The purpose of this disclosure/request is:

___ Coordination of Care ___ Treatment Plan
___ Other _____

This consent may be revoked at any time by providing written notice. By signing this form, the client acknowledges that s/he has been given information about what is to be disclosed/requested, the purpose of this disclosure/request, and who will receive this information. Signing of this form by the patient also releases Sarah Reidy, LCSW, SEP from any legal liability resulting from the release of this information. Consent to this disclosure will expire in eighteen months from the date signed unless otherwise designated below.

Client Signature _____ Date _____

Sarah Reidy, LCSW, SEP Signature _____ Date _____