Megan Lukany LLC
5342 Clark Road, #1248
Sarasota, Florida 34233
973.809.9270
MeganLukanyLLC@gmail.com

CONSENT TO RELEASE

PSYCHIATRIC RECORDS

I, _____, BIRTH DATE ____/____/____,
(print name of client)
hereby authorize Megan Lukany, LCSW/CHES, to have bilateral exchange of information that is contained in my psychiatric record with:

_____
_____
_____

under the conditions listed below:

1. This information will be limited to:
   ____ Psychiatric summary (including diagnosis and treatment focus)
   ____ School-Based-Therapy Progress notes
   ____ Psychological testing.
   ____ Educational testing.
   ____ Academic Records/IEP/504 Plans
   ____ Other:_____

2. Purpose or need for such disclosure:
   ____Continuing Care/Treatment Planning,
   and/or _____
   _____.

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon _____
   _____.
   (Specific Date, Event or Condition)

4. An additional consent must be obtained for any other transfer or disclosure of this information.

5. I understand that I may receive a copy of this release.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent, Guardian or other Person authorized by law to sign in lieu of Patient (where required). Indicate which. Date

_____ _____
Witness (if applicable) Date