Transcendent Therapeutics LLC
Stacy Veo DNP, PMHNP-BC
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Release of Information and Consent Form

_____ _____
Patient Name Date of Birth

I authorize Stacy Veo, DNP, PMHNP-BC to receive/release my protected health information from/to those listed below. This information may be released/obtained and/or shared for the purpose of improving continuity of care.

_____ _____
Primary Care Physician (PCP) Name PCP phone

_____ _____
Therapist Therapist phone

_____
School

_____ _____
Others involved in your care Phone

This release is valid for the duration of treatment with Transcendent Therapeutics LLC or until:_____

I understand the following conditions apply to this Release of Information Consent Form:

1. Stacy Veo DNP, PMHNP-BC cannot be held liable for how other authorized parties protect, store, use, or disclose information that is provided through this Release of Information.
2. I may revoke this Release of Information Consent Form at any time by providing a written request to Stacy Veo DNP, PMHNP-BC and I will not suffer any undue hardships to treatment to the extent that I understand my treatment may be limited by such revocation.
3. I may decline to sign this Release of Information and not suffer any undue hardship in treatment to the extent that I understand my treatment may be limited by such declination.

_____ _____
Patient signature Date

_____ _____
Parent/Guardian Signature if patient is under the age of 18 years old Date