Annie Hotchkiss, LICSW
Licensed Independent Clinical Social Worker
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CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Clients Name: _____

I hereby authorize the following party to release to and/or exchange information with Annie Hotchkiss, LICSW:

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

The purpose of this release is for:

_____ Continuity of care
_____ Coordination of care with another treating healthcare provider
_____ Insurance plan or third-party-payer review of records for quality and level of care and/or justification of charges, and as needed to authorize more sessions or to process claims, or to fulfill administrative review by plan
_____ Other: _____

_____

The information released will be limited to:

_____ Attendance
_____ Summary of pertinent psychiatric and psychosocial history
_____ Treatment summary
_____ Complete mental health assessment and treatment records
_____ Any information deemed necessary to coordinate care
_____ Other_____

The requesting party certifies that information will not be used for any purpose other than its intended use, and will not be re-released to another party. The client understands that s/he has a right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has been already taken in reliance thereon. If not revoked earlier, this consent expires three years from the date signed.

_____ _____
Signature Date

_____
Relationship to Client