Inner Wisdom Counseling, L.L.C.
Linda Najjar, Ph.D.

CONSENT FOR RELEASE OF INFORMATION

I give consent for Inner Wisdom Counseling, L.L.C./Dr. Linda Najjar and the healthcare provider or other party listed below to exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for coordination of treatment, case management, claims processing, quality assurance, or utilization review purposes.

I understand that I can revoke my consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read, and I understand the information above and I authorize Dr. Linda Najjar to contact and exchange information with:

Name of Primary Care Physician OR Other Person/ Organization to whom you want to Release Information:

_____

Telephone: _____-_____-_____ Fax: _____-_____-_____

List any limits on release of information or additional requests if needed:

_____

_____

_____ I would prefer if the release of information was only used if absolutely needed/ requested by my primary care doctor or other person.

_____ I choose not to provide consent for release of information to anyone at this time.

_____

(Printed Name of Patient) (Signature) (Date)