CENTER FOR
INTEGRATIVE PSYCHOTHERAPY

CONSENT TO RELEASE OR OBTAIN CONFIDENTAL INFORMATION

_____ ____/____/____ _____

Patient Name (Please Print) **Date of Birth** **Rendering Therapist Name**

I authorize Center for Integrative Psychotherapy, to Disclose/Receive (circle one) information contained in my record/ my child's record (circle one) to/from (circle one):

Name: _____Organization/Agency:_____Fax: _____

Phone: _____Address:_____City:_____State: ____Zip:_____

Purpose for disclosure: ☐ Continuation of Care ☐ Payment of Claim

☐ Disability and Social Security Application ☐ Coordination of Care with Other Healthcare Provider

☐ Other_____

The information to be released is confined to the following:

☐ Medical History	☐Psychological Evaluations	☐Test scores and profiles
☐ Therapy notes	☐Treatment summary	☐Back ground information
☐ Court testimony	☐Dates of service	☐Other _____

Specific information to be disclosed: ☐ copies ☐ verbal consultation.

- I understand this release will automatically expire on _____.I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to Center for Integrative Psychotherapy. Center for Integrative Psychotherapy and it's staff can not be held legally liable for the interpretation or use by person/persons to whom they are released.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.

The treatment dates covered by this authorization are from_____ to _____.

_____ _____

Patient Signature/ Responsible Party Signature Date

_____ _____

Patient Signature/ Responsible Party Signature Date

_____ _____

Witness/Therapist Signature Date

DISCLOSURE

This information will be disclosed from records who confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibits any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted b such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
A copy of the Authorization shall be deemed valid as original. This Authorization must be signed and dated in front of your therapist or Center for Integrative Psychotherapy's staff.
I have requested a copy of this form. ___ Yes ___ No

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