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CONSENT FOR RELEASE OF INFORMATION

I, _____, whose date of birth is _____, authorize David E. Briggs, LCPC, to disclose to and/or obtain information with:

Name: _____

Relationship:_____ (i.e. physician, teacher, psychiatrist)

Address:_____

City: _____ State: _____ Zip:_____

Phone: _____ FAX: _____

Release of the following information:

____ Assessment
____ Diagnosis
____ Medication Management
____ Psychological/Psychiatric Evaluation
____ Discharge Summary
____ Progress Notes
____ Treatment Plan or Summary
____ Presence/Participation in Treatment
____ Substance Abuse Treatment
____ Other _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____
_____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to David E. Briggs, LCPC at the above address. Unless sooner revoked, this authorization is valid for six months. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains. I understand that David E. Briggs, LCPC will not condition my treatment on whether I give authorization for the requested disclosure.

_____ I refuse to release information at this time.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Therapist/Witness Signature _____Date _____