Joshua M. Noblitt
CREATIVE APPROACHES TO HEALING

Consent to Release Confidential Information

(If you wish to grant permission for your therapist to share any information with a 3rd party)

I, (client name)_____, D.O.B._____
do hereby authorize Joshua M. Noblitt, DMin., LMFT, CST to receive from, release to, or exchange with:

Name/Agency:_____

Address:_____

Phone/Fax/Email:_____

The following information:

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s), including HIV/AIDS information.

For the purpose of:

_____ The development of a treatment / service plan

_____ Coordination of care with family/behavioral health or medical providers

_____ Ongoing treatment/ continual care

_____ Insurance or employment

_____ Other (specify):_____

I understand that the information disclosed above is protected by Federal Health Information Protection Laws, and cannot be released without my written consent unless otherwise required by law. I understand that I need not consent to the disclosure of information in order to obtain treatment services. I choose to do so willingly and voluntarily for the purposes specified above. The duration of this authorization is no longer than one year unless I specify a date, event, or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying Joshua M. Noblitt in writing, except to the extent that action has been taken in good faith on my consent.

Client signature:_____Date:_____

Parent/Guardian/Legal Representative:_____Date:_____

THIS CONSENT WILL AUTOMATICALLY EXPIRE IN ONE YEAR or as specified:_____