Consent to Release Confidential Information

[If you wish to grant permission for therapist to share any info with a 3rd party]

I, (Client name) _____, D.O.B. _____

do hearby authorize: Joshua M. Noblitt, MDiv., LMFT, to receive from, release to, or exchange with:

Name/Agency _____

Address/Phone Number _____

The following information:

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

_____

For the purpose of:

(check all that applies):

_____ The development of a treatment / service plan

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

_____ Ongoing treatment / continuing care

_____ Insurance or employment

_____ Other (Specify): _____

I understand that 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 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 Signature _____ Date _____

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

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