NEW LEAF
PSYCHOTHERAPY SERVICES

CONSENT TO RELEASE/RECEIVE INFORMATION

Initial each choice and provide the name of each professional/organization in the space provided.

I give my consent for _____
to release the following information regarding my case to the following parties:

☐ Primary Care Provider _____

☐ Patient Refuses Permission to Communicate with Primary Care Provider

☐ Insurance Company _____

☐ Health Care Professional _____

☐ Other _____

This release of information consent will include the following:

☐ Treatment Summary

☐ Psychological Evaluation

☐ Discharge Summary

☐ School Transcript

☐ Teacher Reports

☐ Other _____

☐ I give my consent for the above parties to engage in professional conversations regarding my case.

I understand that the above permission is bound by regulations governing confidentiality of medical and psychological records and disclosure to anyone other than the person named above is forbidden without further written authorization.

I also understand that I may revoke my consent to release information at any time.

This consent will expire one year from the date of signature.

_____
Printed Name

_____
Signature

07/30/1990
_____
Date of Birth

_____
Parent or Guardian

_____
Witness

_____
Date

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