Consent for Release of Information

I understand that a behavioral health professional has an obligation to keep my personal information, identify information, and my records confidential. I also understand that I can choose to allow a health professional to release some or all of my personal information to certain individuals or agencies. Communication between health professionals is important to aid in ensuring all care is coordinated.

Name: ______________________________ Date of Birth: ________________________________

*WHO WILL BE EXCHANGING INFORMATION

Title and Name of Agency or Person

Address:

Fax/Phone Number

And

Title and Name of Agency or Person

Address:

Fax/Phone Number

Circle Method of Release
Mobile Phone Fax In Person Email

What information will be shared:

Disclosure purpose:

- **I can revoke this document at any time by writing to Practical Therapeutic Solutions.**
- **Signing a release form is voluntary.**
- **This authorization shall expire upon therapy becoming inactive for the client.**

Signature Signed: ______________________________
Signature Print: __________________________________
Relationship to signer: ___________
Date : ______________