

**Consent for Release of Information**

**Patient Information:**

Name: \_\_\_\_\_ Address \_\_\_\_\_

Date of birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

Telephone : \_\_\_\_\_

**I authorize Jane Thompson, MSW, LICSW, BCD to (check all that apply)**

disclose information

obtain information

exchange information

**Name and address of individual or agency to whom the release & information will be sent:**

\_\_\_\_\_  
\_\_\_\_\_

Telephone : \_\_\_\_\_ Fax: \_\_\_\_\_

\*\*\*\*\*

**For the purpose of:**

payment     coordination of care     continuity of care     other: \_\_\_\_\_

**Please release the following information:**

Billing dates, charges, and clinical data required by insurance company

clinical assessment, treatment plan and progress notes

treatment summary

Other: \_\_\_\_\_

I understand that this release will automatically expire one year from this date. This release may be revoked in writing at any time. Cancellation becomes effective upon receipt of written notice. I understand that a photocopy of the release shall be considered equivalent to the signed original. I understand access to this information will be limited to persons in the office whose work assignment reasonably requires access and that disclosure of this information to parties, other than those stated above, cannot occur without my express written consent, unless required by law.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of parent, representative or legal guardian if patient is a dependent minor**

\_\_\_\_\_ **Date:** \_\_\_\_\_