SELF EXPRESSIONS

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CONSENT FOR RELEASE OF PRIVATE HEALTHCARE INFORMATION

I, _____, hereby authorize _____ of Self Expressions to release and obtain information with the following individual or organization: The purpose of this release is to improve assessment and treatment planning, share information relevant to treatment and to coordinate services.

Name: _____

Address: _____

Phone: _____

Revocation: I understand that I have the right to revoke this authorization at any time by giving written notification to my therapist at Self Expressions. I further understand that a revocation of the authorization is not effective for action that has already taken place with the earlier authorization.

Expiration: I understand that this authorization expires _____, or one year from the date of the signature below.

I understand that once protected healthcare information is disclosed it may be redisclosed by the recipient and may not be protected by federal privacy laws and regulations.

Signature of Client: _____ Date: _____
(or of Parent/ Guardian if client is a minor)

Signature of Witness: _____ Date: _____