

Release of Information - Sarah

** indicates a required field*

*** Client's legal name:**

*** Date of Birth:**

*** I authorize Sarah Dobey, LPC, MAC, ACS, to:**

Send

Receive

The following information:

Medical history and evaluation(s)

Mental health evaluations

Developmental and/or social history

Educational records

Progress notes, and treatment or closing summary

Other

To / From:

(please write below the person or organization that you are allowing us to communicate with)

*** Phone Number of the person or organization you are allowing us to communicate with:**

Email address of the person or organization you are allowing us to communicate with:

*** Your relationship to client:**

Self

Parent/legal guardian

Personal representative

Other

*** The above information will be used for the following purposes:**

Planning appropriate treatment or program

Continuing appropriate treatment or program

Determining eligibility for benefits or program

Case review

Updating files

Other

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this

authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

https://secure.simplepractice.com/practice_settings/intake_questionnaires/6647718/preview 2/3

9/9/21, 4:41 PM Preview intake questionnaire - SimplePractice

Client's Signature:

*

I consent to sharing information provided here.

*** Date:**

Witness signature (if client is unable to sign):

I consent to sharing information provided here.

Witness Date:

Parent/guardians/personal representative signature (if applicable):I consent to sharing information provided here.

Parent/Guardian Date:

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