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Release of Information

I/We understand that different agencies/professionals provide different services, but under the Freedom of Information Act, without my/our permission, any information regarding my/our case cannot be exchanged with another agency/professional.

Client Name: _____ DOB: _____

I authorize: Carolyn Wolfe, LMFT
___ to exchange information with
____ to release information to
____ to receive from

_____
Name of Person, Organization, or Institution

_____
Address and Telephone Number

For the Purpose of Diagnostic assessment and/or treatment planning.
The following confidential information may be exchanged in written form, oral information, and/or computerized data:
____ Medical Records ____ Social Services Record _____ Assessment Information ____ Educational Records ____ Residential Treatment _____ Mental Health Information ____ Psychological Exams ____ Other Information: Please Specify the Information to be released:

_____

This release of information is valid for one year.
I understand that I can withdraw this permission at any time. I have the right to know what information has been shared, why, when, and with whom. I want the above noted agencies/professionals to accept a copy of this form as consent to share information with Carolyn S Wolfe, LMFT, LLC.

Signature: _____

Date: _____