LAUREN B. YERKES, PSY.D., LLC
Licensed Clinical Psychologist
PY 8432

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby consent for Dr. Lauren Yerkes, Psy.D to release Protected Health Information (including symptoms, diagnosis, attendance, treatment progress, and recommendations) regarding ____
(client name)

to____.
(name or agency)

Contact Information (for person or agency receiving information):
Name: ____
Title: ____
Address:____
____
____
Phone Number: ____
Fax Number: ____
E-mail Address: ____

Other than as required or allowed by law, your health information will not be used by or released to other persons or agencies without your written consent. The release authorized herein is required for the purposes of treatment efficacy, client safety and/or payment for psychotherapy services rendered.

This consent shall become effective on ____________________ and (except in limited situations) is subject to revocation by the undersigned at any time except to the extent that the action has already been taken.

_______________________________ _____________________________________
Signature of Client Date

_______________________________ _____________________________________
Client Date of Birth Witness

CONSENT REVOKED:

__________________________________ _____________________________________
Signature of Client Date

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