Heather R. Roberts, MA, LMFT, LPC
Licensed Marriage and Family Therapist
Licensed Professional Counselor
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CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

This consent authorizes Heather R. Roberts, MA, LMFT, LPC or her representative to release the below specified information about:

_____

Name Date of Birth Social Security Number

To: _____
Recipient's Name

_____
Recipient's Contact Information

For the purpose of: (Please initial)

___ Insurance Claim
___ Completing Clinical Assessments
___ Treatment Planning and Coordination
___ Legal Action
___ Continuity of Care
___ Treatment of a Minor Child
___ Referral
___ Other (specify) _____

Information to be disclosed: (Please initial)

___ Discharge Summary
___ Treatment Plan
___ Verbal Communication
___ Summary of Entire Record
___ Other (specify) _____

Record Consent expires on: _____

I understand that I may refuse to release my record. I understand that I may revoke this consent in writing at any time except to the extent that action has already taken place. I understand that Heather R. Roberts, MA, LMFT, LPC has no control over my records once they are released to a third party. I understand I have a right to a duplicate of this form for my record.

_____
Client Signature Date Signed

_____
Legally Qualified Representative Relationship to Patient Date Signed

_____
Witness Signature Date Signed

COMPLETE ONLY IF YOU WISH TO HAVE YOUR CARE COORDINATED WITH ANOTHER HEALTHCARE PROVIDER