Consent to Release Confidential Information to Another (third) Party

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I,_____ (print your name and date of birth) am completing this form to allow the use and sharing of my, (or my child_____) protected health information. I authorize Annie Brogger, MFT, to disclose my (or my child:_____) psychotherapy treatment records (which may include admission and discharge summaries, psychological evaluations, reports, assessments, treatment notes, progress notes, psychotherapy attendance records).
Dates of care for which the information will be disclosed include: Please specify the time period for which you are giving Annie Brogger, MFT, the permission to release your (or your child's) records:

From _____ to _____

I authorize Annie Brogger, LMFT, to disclose the above noted information to this person &/or organization: (list below the person(s) and/or the organization(s) that will be receiving your records from Annie Brogger; please, be sure to provide complete address and contact information for this "third" party)

Name
_____
Street, City:
_____

Zip Code:_____

Phone : (_____) _____-_____

The information will be used/disclosed for the following purposes:
_____
_____
_____
I understand and agree that this Authorization will be valid for one year from this date unless specified otherwise here:
_____
I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
I understand that I can revoke or cancel this authorization at any time by sending a letter to

Annie Brogger, LMFT. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Annie Brogger, MFT. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signature of client or his or her personal representative Date

_____ _____

I (the client) acknowledge that I received a copy of this completed form: _____ (please, initial here) I (the client) have declined the copy of this completed form: _____ (please, initial here)
I, Annie Brogger, LMFT, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Printed name of professional Signature of professional

_____ _____

Date _____