**AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize **Tessa Magill** **MS, LMFT** and

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to exchange information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 *Name* *Location/Telephone*

The type of information to be disclosed:

 Evaluations \_\_\_\_\_ Medical/Hospital Records\_\_\_\_\_ Diagnosis \_\_\_\_\_ Psychological/Medical Test

Results\_\_\_\_\_ Treatment Plan\_\_\_\_\_ Mental Health Record Summary\_\_\_\_\_ Course of Treatment\_\_\_\_\_

Progress to Date\_\_\_\_ Psychotherapy Notes \_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of such disclosure:

 Ongoing Treatment\_\_\_\_\_ Medical Care\_\_\_\_\_ Consultation\_\_\_\_\_ Evaluation\_\_\_\_\_ Transfer\_\_\_\_\_

Legal issues\_\_\_\_\_ Coordination of Care\_\_\_\_\_ Health Benefit Utilization\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_

Exceptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The designated information about me may be transmitted by fax, electronic mail or other

electronic file transfer mechanisms. **Tessa Magill** and the above designated person may

discuss by telephone the content of the information released. I agree that a photocopy of this

release shall be as valid as the original. I understand that my communications in therapy are

protected under federal and state confidentiality regulations and cannot be disclosed without

my written authorization. The information provided by a client during therapy sessions is

legally confidential in the case of licensed marriage and family therapists, except for certain

legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and

to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health

information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and

disadvantages of releasing the information, if known, have been explained to me.

This consent is in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(One year from today’s date)*

I understand that I may revoke this authorization, in writing, at any time unless action based

on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this

information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Date) (Signature of Client or Personal Representative*