



**General Consent to Release Information
Authorization of Disclosure**

I, _____, Date of Birth _____

Authorize James McCormack, MA-LMFTA, RHT, to exchange information with:

Name/Organization: _____ Phone: _____

Address: _____ Fax: _____

Specific nature of information to be released:

- | | |
|--|---|
| <input type="checkbox"/> any or all of the following | <input type="checkbox"/> summary of treatment |
| <input type="checkbox"/> attendance/scheduling/transportation; | <input type="checkbox"/> response to treatment/progress |
| <input type="checkbox"/> information related to payment | <input type="checkbox"/> presenting complaints/issues |
| <input type="checkbox"/> recommendations/suggestions | <input type="checkbox"/> legal information |
| <input type="checkbox"/> diagnosis and/or assessment results | <input type="checkbox"/> grade/performance information |
| <input type="checkbox"/> treatment plan and goals | <input type="checkbox"/> other: _____ |

The information above is being released for the purpose of:

- facilitating consultation and/or collaboration
 facilitating continuity of treatment
 facilitating scheduling/transportation
 other: _____

I understand that:

- This consent will automatically expire in one year from signing unless a different date of expiration is specified here: _____
- I have the right to copy and inspect the information being disclosed.
- I have the right to revoke this authorization, in writing, at any time by sending such written notification to my provider's office except to the extent that action has been taken in reliance on it, and that in any event this consent expires at the end of services recommended.
- I also understand that this information may not be released to any other person or organization without my permission in writing.
- A photocopy/facsimile of this authorization shall be considered valid.
- I further acknowledge that the information to be released was fully explained to me and this consent was given of my own free will.

Patient/Client (Adult or Minor 13 or older)

Date

Parent or Legal Guardian

Date

Witness

Date