CONSENT TO RELEASE INFORMATION

Communication between behavioral health providers is important to help ensure comprehensive, coordinated and quality care. Such communication requires your consent. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire 6 (six) months from the date of signature, unless another date is specified.

I, ___________________________________for the purpose of coordinating care, authorize Margaret Lang-Garnhart, LCSW, at Evergreen Counseling Center, PLLC, to release information about:

_____ goals and progress of treatment

_____ any applicable mental health/substance abuse information.

_____ medication information

_____ ____

to:

Name ____

Agency/Contact Information: ____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. In have read and understand the above information and give my consent.

_____________________________________ _________________________

Client Signature Date

_____________________________________ _________________________

Witness Signature Date

Notice to Recipient of This Information: This information has been disclosed to you from records which are protected by Federal and State laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.