INSIGHTS COLLABORATIVE THERAPY GROUP
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CONSENT TO RELEASE
(adult)

I authorize _____ to release to, obtain from, and discuss with name: _____ phone: _____ the following information concerning me (client to check each item to be disclosed):

____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Testing Information
____ Educational Information
____ Presence/Participation in Treatment
____ Continuing Care Plan
____ Treatment Progress
____ Billing Records Only

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and, when appropriate, coordinate treatment services.

I waive my right to confidentiality of the information and records released, obtained and discussed under this Consent. I release Insights Collaborative Therapy Group and its staff from all liability arising from release, disclosure and discussion of my confidential information and records.

This Consent expires _____. I acknowledge I have the right to revoke this Consent in writing at any time to the extent action in reliance on this Consent has not been taken. I acknowledge that even if I revoke this Consent, the use and disclosure of my protected health information could possibly still be compelled as required by law. I have been advised of the potential of the redisclosure of my protected health information by the authorized recipients.

I acknowledge that the treatment provided to me by Insights Collaborative Therapy Group was not conditioned on my signing this authorization. I acknowledge I signed the original of this Consent to Release and received a copy of it.

DATED: _____, 201__.

Client:

_____
Client Signature

_____
Client Name Printed