



**CONSENT TO RELEASE**

(adult)

**INSIGHTS COLLABORATIVE THERAPY GROUP**

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Dallas, Texas 75231  
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**Select clinician:**

- Dr. Jeff Baldrige, PhD (jbaldrige@insightstherapy.com)
- Mary Sanger, LMFT-S, LPC-S, LCDC (msanger@insightstherapy.com)
- Murphy Foster, LPC (mfoster@insightstherapy.com)
- Laura Pierce, LMFT-S, RPT, IMH-E (laura@insightstherapy.com)
- Shawn Chrisman, PhD, LPC (schrisman@insightstherapy.com)
- Jennifer Aguilar, LPC (jennifer@insightstherapy.com)
- Elizabeth McConnell (elizabeth@insightstherapy.com)
- Other: \_\_\_\_\_

I authorize the above selected clinician to release to, obtain from, and discuss with \_\_\_\_\_

\_\_\_\_\_ the following information concerning me:

- |  |  |
|--|--|
| <input type="checkbox"/> Assessment                | <input type="checkbox"/> Educational Information             |
| <input type="checkbox"/> Diagnosis                 | <input type="checkbox"/> Presence/Participation in Treatment |
| <input type="checkbox"/> Psychosocial Evaluation   | <input type="checkbox"/> Continuing Care Plan                |
| <input type="checkbox"/> Psychological Evaluation  | <input type="checkbox"/> Treatment Progress                  |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Billing Records Only                |
| <input type="checkbox"/> Current Treatment Update  | <input type="checkbox"/> Alcohol and Substance Abuse         |
| <input type="checkbox"/> Testing Information       |  |

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 child's 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: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME