PEACE OF MIND THERAPY • 6502 GRAND TETON PLAZA STE 204 • MADISON, WI 53719

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REQUEST FOR AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

I, *(CLIENT)* HEREBY AUTHORIZE **PEACE OF MIND**

THERAPY & *(CLINICIAN)* *TO (SPECIFY BY CHECKING ONE BOX BELOW)*

☐ **RELEASE INFORMATION TO:** **(OR)** ☐ **OBTAIN INFORMATION FROM:**

PERSON OR FACILITY

PHONE NUMBER FAX

FOR THE PURPOSE OF *(PLEASE CHECK ALL APPROPRIATE BOXES BELOW)*

☐ Further mental health evaluation and treatment ☐ Treatment planning ☐ Other

☐ Update for current or prior provider ☐ Emergency Contact

These records concern the time **between** *(specify dates)* and .

The information to be disclosed is CHECKED below with a brief *optional* written summary:

☐ Intake and discharge summaries ☐ Medical history and evaluation(s)

☐ Diagnostic impressions and treatment goals summary ☐ Progress notes

☐ Developmental and/or social history ☐ Other

WRITTEN SUMMARY OF REQUEST *(OPTIONAL)*

CLIENT NAME AND DATE

CLIENT SIGNATURE

THERAPIST SIGNATURE AND DATE

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed or upon fulfillment of the purposes stated above.