Medical & Mental Health Release

From the office of

Patty Emberley, MA, LMFT, LPC

I, __________________________(Client's name, printed), (DOB): ________
Hereby authorize Patty Emberley MA, LMFT, LPC to:
(   ) Disclose to   (   ) Obtain from

Group/Individual/Facility name(s): _________________________________

Address: ____

Telephone: _______________________ Fax: ________________________

Medical and/or Mental Health:
Circle appropriate request(s):
1 – Evaluation   2 – Treatment Summary   3 – Testing
4 – Hospital, Discharge Summary   5 – Educational Records
6 – Progress Notes 7 – Medical Notes/Information 8 – Therapist Files
9 – Any and All Information

About me: ________________________________
While I was a patient between the dates of _________and ________.

The purpose of the release of this information shall be for:
1 – Further health care   2 – Treatment planning
3 – Educational planning   4 – other _______________________________

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records, information, implications of its release and is made voluntarily on my part.
I understand I may revoke this consent at any time within ninety days except to the extent that action based upon this consent has been taken. This consent will expire on __________or upon written notice by the person listed above or upon fulfillment of the above purposes.

Client Signature: _____________________________Date: _____________

Therapist Signature: ____________________________Date: ____________

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PROHIBITION OF REDISCLOSURE

Enclosed information may have been disclosed from confidential records protected by Federal Law. These regulations prohibit redisclosure of confidential information without written consent of the person to whom it may pertain.