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CONSENT TO SHARE/RELEASE INFORMATION

_____ _____
Patient Name (Please Print) **Date of Birth**

I authorize Phase 3 Counseling & Consultation PLLC , to disclose/receive (circle one) information contained in my record to/from (circle one):

Name_____Organization/Agency_____Fax:_____

Address _____City _____State _____Zip_____

Purpose for disclosure: ▫ Coordination of Care ▫ Treatment Planning

Information requested: ▫ Treatment notes ▫ Treatment Summary ▫ Hospital records

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I authorize Phase 3 Counseling & Consultation, PLLC to have ongoing communication via phone, email, video from the following person(s) or organization:

Name/Organization _____

Email_____ Phone _____

Relationship to Client _____

Address _____City _____State _____Zip_____

Purpose for communication: ▫ Coordination of Care ▫ Payment of Care

The information to be released is confined to the following:

Specific information to be disclosed: ▫ copies ▫ verbal consultation

- I understand this release is remains in effect until revocation of this authorization is received. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to: Phase 3 Counseling & Consultation, PLLC. Phase 3 Counseling & Consultation, PLLC cannot be held legally liable for the interpretation or use by person/persons to whom they are released.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/ information for the purpose(s) stated above.

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date