NOLA Art Therapy and Counseling, LLC

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Name_____ DOB_____

THE PERSON LISTED ABOVE IS GIVING CONSENT FOR THE BELOW INFORMATION TO BE RELEASED FOR THE PURPOSE TO ASSIST IN MENTAL HEALTH TREATMENT.

To: NOLA Art Therapy and Counseling From: _____(Name)

_____(Phone)

_____VERBAL/WRITTEN INFORMATION RELATED TO CLIENT'S EMOTIONAL/BEHAVIORAL PROBLEMS AND TREATMENT

_____ PSYCHOSOCIAL ASSESSMENT / ADMISSION SUMMARY

_____ TREATMENT PLAN

_____ COUNSELING/PROGRESS NOTES FROM PAST 6 MONTHS

_____ MEDICATION MGT NOTES FROM PAST 6 MONTHS

_____ MEDICATION SHEETS/MAR (FROM INPATIENT/RESIDENTIAL FACILITY)

_____DISCHARGE SUMMARY

_____PSYCHIATRIC / PSYCHOLOGICAL EVALUATION

_____COURT/PROBATION RECORDS FROM PAST 6 MONTHS

_____OTHER _____

From: NOLA Art Therapy and Counseling To: Above Named Individual

_____ ASSESSMENT/ TREATMENT PLAN

_____VERBAL/WRITTEN INFORMATION RELATED TO CLIENT'S EMOTIONAL/ BEHAVIORAL PROBLEMS AND TREATMENT

_____OTHER:_____

*** I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND IF I REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO NOLA ART THERAPY AND COUNSELING. I UNDERSTAND THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION.**

*** I UNDERSTAND THAT AUTHORIZING THIS DISCLOSURE IS VOLUNTARY. I MAY REFUSE TO SIGN THIS AUTHORIZATION. I UNDERSTAND ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED REDISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. IF I HAVE ANY QUESTIONS ABOUT DISCLOSURE OF MY INFORMATION, I CAN CONTACT NOLA ART THERAPY AND COUNSELING.**

CLIENT _____ DATE _____

Revised 6/21/19