DeYoung Consulting

Safe, Stable, Successful Families.

Consent for Release of Information

Client Name:

Address:

Address:

City, State:

Telephone:

Records to be Produced:
(Place an 'x' beside the requested information)

Initial Evaluation: ____________________

Summary of Treatment: ____________________

Psychotherapy notes: ____________________

Billing Records: ____________________

Termination Summary: ____________________

Other: ____________________
(Please Describe):

____

I, the undersigned, hereby consent to, direct, and authorize, Dr. Mark DeYoung, LMFT, to release or disclose to:

Name:

Address:

City, State:

Telephone:

For the period of time from:

through the date this consent is signed by me. The information or records to be released or disclosed are indicated above.

Fax:

If the records are released to a doctor, psychologist, therapist, counselor or other professional licensed to provide medical or mental health treatment, I authorize Dr. Mark DeYoung to consult with the above named provider concerning my therapy.
I acknowledge that I have the right to revoke this authorization in writing at any time to the extent Dr. Mark DeYoung, LMFT, has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be compelled pursuant to law as indicated in the copy of the Notice of Privacy Practices of Dr. Mark DeYoung, LMFT, that I have receive and reviewed.
I acknowledge that I have been advised by Dr. Mark DeYoung, LMFT of the potential of the redisclosure of my Protected Health Information by the authorized recipients and that if will no longer be protected by the federal Privacy Rule.
I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information release pursuant to this consent and herby release Dr. Mark DeYoung, LMFT, and his staff from any and all liability arising from the release and disclosure of the information and records to:

I further acknowledge that the treatment provided to me by Dr. Mark DeYoung, LMFT was not conditioned on my signing this authorization.

Client: ____________________ Therapist: ____________________

I acknowledge that I received a copy of this signed authorization form Dr. Mark DeYoung, LMFT on this __________ day of ________________ ,20 Client: ____________________