



## CONSENT FOR RELEASE OF CONFIDENTIAL CLIENT INFORMATION

This consent authorizes \_\_\_\_\_  
Facility/Organization/Individual Releasing Information

to exchange the following information on \_\_\_\_\_  
Client Name/Insurance #

From/To:

Laurie Marcellin MA,LPCC, NCC

enCOURAGE COUNSELING, LLC

720-230-3076

laurie@encouragetherapy.com

For the purpose of:

\_\_\_\_\_ Insurance claim

Insurance company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Member Name/DOB: \_\_\_\_\_

\_\_\_\_\_ Continued care by another physician or health care facility

\_\_\_\_\_ Referred to mental health specialist for continued care

\_\_\_\_\_ Assessment, treatment planning, continuity of care



## CONSENT FOR RELEASE OF CONFIDENTIAL CLIENT INFORMATION

### The information to be disclosed:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Intake Assessment | <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Psychiatric History                    |
| <input type="checkbox"/> Treatment Plan    | <input type="checkbox"/> Psychological Test | <input type="checkbox"/> Discharge Summary                      |
| <input type="checkbox"/> Social History    | <input type="checkbox"/> Psychological Test | <input type="checkbox"/> Medical History & Physical Examination |

Release is valid from \_\_\_\_\_ until \_\_\_\_\_

I understand that I may revoke this consent at any time. This consent will expire 90 days from the date of discharge. To the receiving party of this information - this information has been disclosed to you for the sole purpose stated in the consent any other use of this information without the expressed written consent of the patient is prohibited.

\_\_\_\_\_  
Client or Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date