
Patient Name

Patient ID #

I authorize **Solutions Counseling and Consultation Services** to disclose, release, and/or obtain records to/from my primary care physician/group and my health insurance/behavioral health company/employee assistance program for the purpose of coordinating my treatment. In addition, I authorize Solutions Counseling & Consultation Services and any psychiatrist I may consult with regarding my treatment to communicate with each other. Any additional parties I have checked below and Solutions Counseling & Consultation Services may also communicate regarding information relating to my assessment, psychotherapy notes, admission, diagnosis, social history, school data, psychological tests, and treatment progress for purposes of evaluation and treatment. I understand that confidentiality will be waived if mandated by law (such as child abuse) or to prevent a clear and present danger to myself and/or another. I am aware that Health Insurance Portability and Accountability Act (HIPAA) information regarding the privacy of my health information has been made available to me.

PLEASE CHECK ALL THAT APPLY: (include addresses, telephone/fax numbers)

- My spouse _____
- My family member(s) _____
- My lawyer _____
- My previous therapist _____
- My school district _____
- My employer _____
- The person who referred me _____
- Other _____

I understand that this release must be signed for any treatment with medication. I understand that all medication information must be shared with my **primary care physician**. I understand my signature gives consent for evaluation and treatment.

Patient signature (14 and older)

Date

Parent/guardian signature (if under 18)

Date