Solutions
Counseling & Consultation Services

_____
Patient Name

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 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 may also communicate regarding information relating to my assessment, psychotherapy notes, admission, diagnosis, social history, school data, psychological tests, and treatment progress for purpose 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 contact information)

( ) My spouse_____

( ) My family member(s)_____

( ) My lawyer_____

( ) My previous therapist_____

( ) My school district_____

( ) My employer_____

( ) 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 PCP. I understand my signature gives consent for evaluation and treatment.

_____ _____
Patient signature (14 and older) Date

_____ _____
Parent/guardian signature (if under 18) Date

b/roi
rev 11/19