SFC change

PERALES THERAPY

CONSENT TO RELEASE INFORMATION

Patient First and Last Name: DOB: / /

Patient Address:

City, State, Zip: Patient Phone Number:

I authorize the disclosure of my personal and protected health information and allow Nina Perales, LCSW to

(Please initial) _____get information from and _____share information with the below entity:

Name: Nature of Relationship:

Address:

Phone Number: Fax Number:

The purpose for sharing is for treatment planning and collaboration on care. Please initial what you want to release:

☐ Appointment Information	☐ Treatment Plans & Prognosis	☐ Health History including medications, diagnosis, and chronic conditions	☐ Other:
☐ Mental & Behavioral Health Diagnosis	☐ HIV/AIDS Dx	☐ Substance or Chemical Dependency	☐ No Limit

This authorization expires on _____, in 365 days or upon case closure. I may revoke authorization at any time by submitting my request in writing, except to the extent in which information had already been released. I sign this form voluntarily and know my treatment is not conditioned on me signing this. I understand that once records have been released, they may be re-released and SFC Change will not be held liable.

Client Signature: Signature of Witness:

Date: Date:

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