

NOLA Art Therapy and Counseling, LLC

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Name _____ DOB _____

THE ADULT LISTED ABOVE IS GIVING CONSENT FOR THE BELOW INFORMATION TO BE RELEASED FOR THE PURPOSE: **To assist in mental health treatment**

To: **NOLA Art Therapy and Counseling** From: _____ (Name)

_____ (Phone)

_____ VERBAL/WRITTEN INFORMATION RELATED TO CLIENT'S EMOTIONAL/BEHAVIORAL PROBLEMS AND TREATMENT

_____ PSYCHOSOCIAL ASSESSMENT / ADMISSION SUMMARY

_____ TREATMENT PLAN

_____ COUNSELING/PROGRESS NOTES FROM PAST 3 MONTHS

_____ MEDICATION MGT NOTES FROM PAST 6 MONTHS

_____ MEDICATION SHEETS/MAR (FROM INPATIENT/RESIDENTIAL FACILITY)

_____ DISCHARGE SUMMARY

_____ PSYCHIATRIC / PSYCHOLOGICAL EVALUATION

_____ COURT/PROBATION RECORDS FROM PAST 6 MONTHS

_____ OTHER _____

From: **NOLA Art Therapy and Counseling** To: **Above Named Individual**

_____ ASSESSMENT/ TREATMENT PLAN

_____ MEDICATION MANAGEMENT RECORDS (WRITTEN/VERBAL)

_____ VERBAL/WRITTEN INFORMATION RELATED TO CLIENT'S EMOTIONAL/ BEHAVIORAL PROBLEMS AND TREATMENT

_____ OTHER: _____

* I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND IF I REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO NOLA ART THERAPY AND COUNSELING. I UNDERSTAND THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON _____ . IF I FAIL TO SPECIFY AN EXPIRATION DATE, THIS AUTHORIZATION WILL EXPIRE 6 MONTHS FROM THE DATE THIS AUTHORIZATION IS SIGNED.

* I UNDERSTAND THAT AUTHORIZING THIS DISCLOSURE IS VOLUNTARY. I MAY REFUSE TO SIGN THIS AUTHORIZATION. I UNDERSTAND ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED REDISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. IF I HAVE ANY QUESTIONS ABOUT DISCLOSURE OF MY CHILD'S INFORMATION, I CAN CONTACT NOLA ART THERAPY AND COUNSELING.

* I CERTIFY BY MY SIGNATURE THAT I AM THE PARENT/LEGAL CARETAKER OF THE CHILD LISTED ABOVE AND/OR AUTHORIZED/DESIGNATED CARETAKER.

CLIENT _____ DATE _____