southeastern telepsychiatry

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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

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I, _____ (client), hereby authorize Southeastern Telepsychiatry and the following party or parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis:

(1) _____

(2) _____

(3) _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

_____

_____

Additionally, the above named parties, clinician & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.
Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named Southeastern Telepsychiatry at the above address to be effective.

Client's Signature:_____ Date: _____

Parent's/Legal Guardian's Signature:_____ Date: _____