ELEMENTAL COUNSELING & CONSULTING, LLC
CREATING PATHWAYS FOR CONNECTION

Consent for Release & Exchange of Information (ROI)

Client Name: _____

Date of Birth (D.O.B.):_____

I hereby authorize the following party to release to and/or exchange information with:

- Natasha Finney, IMFT-S, LPC

Name: _____

Address: _____

Phone: _____

Fax:_____

Email: _____

The purpose of this release is for:

_____ Continuity of care
_____ Coordination of care with another healthcare provider
_____ Insurance plan or third party-payer review of records for quality and level of care and/or justification of charges, and as needed to authorize additional sessions or to process claims, or to fulfill administrative review by plan
_____ Other: _____

Information released will be limited to:

_____ Attendance
_____ Summary of pertinent psychiatric and psychosocial history
_____ Treatment summary
_____ Complete mental health assessment and treatment records
_____ Any information deemed necessary to coordinate care
_____ Other: _____

The requesting party certifies that information will not be used for any purpose other than its intended use and will not be re-released to another party. The client understands that s/he has a right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has been already taken in reliance thereon. If not revoked earlier, this consent expires one year from the date signed.

X_____
Client(s)/Guardian(s) Signature Date

X_____
Witness Date