Consent to Release and Receive Client Records/Information

CLIENT: Name:
Date of Birth:

I, the undersigned, hereby consent to, direct and authorize *Heather Astill, LSCSW* to ***release and receive information*** from my medical, educational, psychiatric / drug / alcohol records – specifically :

- ☐ Outpatient Therapy
- ☐ All Prior Episodes of Treatment
- ☐ A copy or the portion of the record pertaining to:
- ☐ Other:

Information may be released to/received from: *Heather Astill, LSCSW*
(913) 735-6771
hastill.therapy@protonmail.com

Information may be released to/received from: Name:
Address:
Telephone:
Email:

For the following purpose(s):

- ☐ Facilitation of Assessment
- ☐ Coordination of Treatment and Support
- ☐ Monitoring Progress
- ☐ Coordination of Payment for Professional Services Rendered
- ☐ All of the Above
- ☐ Other:_____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 12 months after the date of client termination unless another date is specified. For reimbursement purposes this authorization shall remain in effect until full reimbursement for services has been received by this therapist.

Specification of the date, event or condition upon which this consent expires: *one year from date of last contact.*

Signature of Client: _____ Date:_____

Signature of Therapist: _____ Date:_____

PROHIBITION ON REDISCLOSURE: THIS INFORMATION IS BEING DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY LAW. FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS IS PROHIBITED BY LAW CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION.