Atlantic Counseling & Consultation, Inc. *Est. 1982*

49 Pleasant Street, Weymouth, MA 02190, (P) 781-335-6000, (F) 781-340-5358

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

This form is to be completed if the patient requests a third party (a doctor, parent of a child over the age of 18, spouse and/or other agency or person) to be involved with his/her treatment at Atlantic Counseling.

I _____ Date of Birth _____

Authorize my provider(s) from Atlantic Counseling (list them)_____

_____

To release to or receive from _____

_____Mental Health ____Current Diagnosis ____Follow up Appointment Dates

_____I authorize the ongoing exchange of information between the two parties' named above.

For the purpose of ( ) Continuing Treatment ( ) Care by Another Professional or Agency ( ) Insurance Claim ( ) Other (specify) _____

The information to be disclosed**: (PLEASE CHECK ALL THAT APPLY)**

( ) Medical Records
( ) Current Medications
( ) Psychotherapy Progress Data
( ) Other

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon and if not revoked sooner in writing, this consent will expire 12 months from the day signed.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed written consent of the patient is prohibited.

Signature of Patient: _____ Date_____

Signature of Guardian (if a minor):_____ Date_____