Barbara Carr-Goodman, LCSW, ACSW
Counseling for Health and Wellness

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## CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION

This form authorizes me to release and obtain protected information from your clinical record to the person(s) you designate.

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_____ I consent to and authorize Barbara Carr-Goodman, LCSW, ACSW, to release or disclose to the person(s) designated below confidential records or information for the purposes of evaluation and/or treatment.

_____ I consent to and authorize the person(s) designated below to release or disclose to Barbara Carr-Goodman, LCSW, ACSW, confidential records or information for the purposes of evaluation and/or treatment.

_____ I also authorize Barbara Carr-Goodman, LCSW, ACSW, and the person(s) designated below to consult with each other concerning my therapy and/or treatment.

The information or records to be released or disclosed should include:

_____ Any and all records/information
_____ Initial evaluation/history
_____ Medical information
_____ Therapy notes
_____ Psychiatric/Psychological reports
_____ Academic reports
_____ Billing records
_____ Transfer/termination summary
_____ Other

Designated person(s): _____
_____

This authorization shall remain in effect until (indefinite if left blank): _____ / _____ / _____

I acknowledge that I have the right to revoke this authorization, in writing, at any time. However, such revocation will not be effective to the extent that Barbara Carr-Goodman, LCSW, ACSW, has acted in reliance on the authorization or if otherwise required by law. I acknowledge that information used or disclosed pursuant to this authorization may be

subject to redisclosure by the authorized recipient(s) of this information and no longer protected by the HIPAA Privacy Rule.

I understand and acknowledge that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Barbara Carr-Goodman, LCSW, ACSW, from any and all liability arising from release and disclosure of such information and records.

I further acknowledge that the therapy provided to me by Barbara Carr-Goodman, LCSW, ACSW, is not conditioned on my signing this authorization.

_____

Client's Name (please print)

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date