



Janet Bastien LMFT

Carlsbad Family Counseling, Inc.

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CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Clients Name: _____

I hereby authorize the following party to release to and/or exchange information with Janet K. Bastien MFT:

Name: _____

Address: _____

Phone: _____ Fax: _____

The purpose of this release is for:

- ___ Continuity of care
- ___ Coordination of care with another treating 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 more sessions or to process claims, or to fulfill administrative review by plan
- ___ Other: _____

The 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 three years from the date signed.

Signature

Date

Second Party Signature

Date