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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____
(Name of patient) (date of birth) (social security number)

Hereby authorize Marie Ritchie-Nicholas, LCSW _____ to disclose to _____ to obtain from:

Person(s) _____ Organization _____

Address _____ City _____ State _____ Zip _____ Phone _____

Information pertaining to my medical care and treatment including psychiatric, drug abuse and /or alcoholism records or communicable disease. Information required:

____ Termination/Discharge Summary ____ Therapist Evaluations
____ Psychiatric/Psychological Evaluation ____ Progress Notes
____ Medical History ____ Psychological Assessment
____ Treatment Plan ____ Psychological Testing
____ Other (Specify) _____

This consent is for the period: ____ A. Beginning _____ and ending _____.
____ B. Duration of Treatment.
____ C. ____ months after patient signature.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, INCLUDING BUT NOT LIMITED TO DISEASES SUCH AS VENEREAL DISEASE, HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

NOTICE TO PATIENTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances including release to persons who have had risk exposures, release pursuant to an order of the court of the Department of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

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