AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO PROFESSIONALS

Beverly Reimers, MA LMHC GMHS ACT (Academy of Cognitive Therapy)

Name of patient: ______________________________ Date of birth: ____________ Social Security #: __________________

I understand that my records contain information about my therapy sessions and my mental health. I understand that all my records are protected by state and federal laws that require they are kept confidential and require my written consent to disclose.

I, _________________________________, hereby authorize Beverly Reimers, MA LMHC to disclose progress notes, treatment plans and any other information pertaining to my mental health and well-being to ____________________ for the sole purpose of the following: Allow and promote exchange of information to assist in my ongoing therapy.

I understand that I have the right to revoke this release at any time. This release will expire when therapy with Beverly Reimers, MA LMHC is terminated.

I have been informed and understand this authorization to release records and information, the nature of listed content that I am willing to release, and the implications of their release. This request is voluntary.

_____________________________________ _____________________________________ _____________

Signature of client | Printed name | Date

_____________________________________ _________________________ _______________ _____________

Signature of parent/guardian/representative | Printed name | Relationship | Date

I witnessed that the person understood the content of this authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____________________________________ _____________________________________ _____________

Signature of witness | Printed name | Date

❑ Copy for patient or parent/guardian ❑ Copy for professional/clinic ❑ Copy for family member

This is a confidential patient record.