William K. Galer, LMFT
Psychotherapy and Evaluation Services

Consent for Release of Information

Client Information

Client Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Consent

I, _____, authorize William K. Galer, LMFT to: **Send** _____ **/Receive** _____ the following information to / from:

Name: _____ Relation: _____

Address: _____

Home Phone: _____ Cell Phone: _____

for the purpose of obtaining necessary information to complete evaluation and communicating with referring entities. I understand that information may be shared verbally, by fax, by email, or in writing by postal mail unless otherwise specified.

I authorize the following information to be shared:

Psychological Testing Result(s)	_____	Medical Report(s)	_____
Psychiatric Evaluation(s)	_____	Subject / Patient History Forms	_____
Financial Information	_____	Insurance Benefit Information	_____
Bio-Psychosocial Assessment	_____	Substance Abuse Test Results	_____
Treatment Plan / Summary	_____	Discharge Letter / Summary	_____
Other: _____	_____		

I understand that Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Subject / Patient Records, Chapter 1, Part 2), plus applicable state laws may protect this information. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

_____ _____
Client Name (Print) Client (Signature) Date

_____ _____
Parent/Legal Guardian (Print) Parent/Legal Guardian (Signature) Date

_____ _____
Witness Name (Print) Witness (Signature) Date