

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby consent for Dr. Lauren Yerkes, Psy.D to release Protected Health Information (including symptoms, diagnosis, attendance, treatment progress, and recommendations) regarding _____
(client name)

to _____
(name or agency)

Contact Information (for person or agency receiving information):

Name: _____

Title: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-mail Address: _____

Other than as required or allowed by law, your health information will not be used by or released to other persons or agencies without your written consent. The release authorized herein is required for the purposes of treatment efficacy, client safety and/or payment for psychotherapy services rendered.

This consent shall become effective on _____ and (except in limited situations) is subject to revocation by the undersigned at any time except to the extent that the action has already been taken.

Signature of Client

Date

Client Date of Birth

Witness

CONSENT REVOKED:

Signature of Client

Date