

Consent For Treatment

Nahal Delpassand, PsyD, PLLC
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RELEASE OF INFORMATION

Name of Client: _____

Date of Birth: _____

_____ (initial) I hereby give permission to **Nahal Delpassand, PsyD, PLLC** to release, orally or in writing, information concerning me to the person or agency named below.

_____ (initial) I hereby give permission to the person or agency named below to release, orally or in writing, information concerning me to **Nahal Delpassand, PsyD, PLLC**.

_____ (initial) I additionally hereby give permission for the disclosure to include information in my records about alcohol, drugs, and HIV status.

Individual or Agency with whom information is to be shared:

Name: _____ Phone: _____
Address: _____ Fax: _____

This authorization is limited to the following types of information:

- Confirm status in therapy Relevant history
- Evaluation of progress Diagnosis
- Treatment plan Treatment summary
- All information Phone consultation
- Other: _____

This release of information is necessary for the purpose of:

- Continuity of care
- Coordination of treatment services
- Referral
- Other: _____

This request has been made voluntarily and without coercion. I understand that this authorization to release information will expire on _____, and that I may terminate it at any time, in writing, if I so desire.

Client Signature

Date

Witness Signature

Date