

Consent for Release of Information

I _____ authorize the Therapeutic and Wellness Solution
(Name of Client)
Center to release / exchange information with _____

(Name, Title, Phone Number, Address)

This release of information is for the purpose of treatment planning, evaluation, and coordination of care. This information may include but is not limited to:

- Verification of services (treatment dates)
- Treatment outcomes
- Medical history including assessments, examinations, diagnosis, prognosis, etc.
- Treatment goals
- Educational records including attendance, assessments, testing results, psychological testing, treatment plans, etc.
- Social / emotional / occupational functioning
- Other

I understand that I do not need to consent to the release of information in order to obtain psychotherapy services through Therapeutic and Wellness Solution Center. I choose to willingly provide a release of information based on the information above. I understand that I am able to terminate this Consent for Release of Information at any time and for any reason, by notifying my therapist in writing. All consent forms will naturally expire 60 days following termination, unless I specify a date, condition, or event in which it is to expire sooner.

Client Name

Client Signature

Date