JAMES GOODMON, LMFT
1501 East Hillside Drive
Bloomington, IN 47401
(812) 320-8285

Release of Information Consent

Client Name: _____ Date of birth: _____
Address: _____Telephone: _____

I hereby authorize: **James Goodmon, LMFT**

____to release information to: Name: _____
____to obtain information from: Relationship to client: _____
____to exchange information with: Address: _____
Telephone #: _____

The information requested or authorized for release or exchange pertains to:

____Mental Health Information *May include Biopsychosocial History and Mental Health Evaluations
____Participation/ Progress in Treatment Update
____Discharge/Transfer Summary
____Psychotherapy Progress Notes *Cannot be combined with any other disclosure.
____Medical History, Medication Management Information
____Substance Use Information

This information may be used or disclosed with the purpose of:

____Planning appropriate treatment
____Continuing appropriate treatment and care
____Determining eligibility for benefits or care
____Safety Planning
____Case Review/Updating Files
____Other:
_____

- We reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. Unless otherwise specified in writing that the disclosure be made in a certain format _____

- I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. This consent automatically expires after 90 days unless otherwise specified on the following date: _____

- 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. I understand that once my information has been released, the recipient might re-disclose it, my provider has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____

Client Signature Date

_____

Signature of Parent, Guardian or Personal Representative Date
(Please include your authority to act for this individual)

_____

Provider/Witness Signature Date