PATRICIA E. CONE, MA, LCMHC

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Release of Confidential Information

Client_____Therapist_____

I hereby authorize Patricia E. Cone Counseling Office to:

_____ send a summary or verbally communicate about my treatment with him/her:

_____request a verbal and/or written summary from:

Name_____Phone_____Fax_____

Address_____

The type of information to be released includes:

_____ Information necessary to coordinate services
_____ Summary of contacts
_____ Psycho-diagnostic assessment DSM-IV-R
_____ Results of psychological testing
_____ Medical history and diagnosis

The patient and/or legal guardian may revoke this consent at any time except to the extent that action has already been taken. This consent will expire within 90 days from the date of signing unless otherwise specified. I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise stated.

Signature_____Date_____