Jim Cosenza, LCSW, CADC

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Mental Health Treatment Release Authorization

Date: _____

I, _____
Patient First Name Patient Middle Initial Patient Last Name

residing at _____
Street Address Apartment or Unit Number City State Zip

Date of Birth: _____ and Telephone Number: _____

hereby authorize and request **Jim Cosenza, LCSW, CADC and staff** to obtain and disclose written, oral, or electronic information with:

Person, Agency, or Facility: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **FAX:** _____

the following information: (please initial in boxes)

☐ initials	Assessment	☐ initials	Participation in Treatment
☐ initials	Diagnosis	☐ initials	Medical Information
☐ initials	Psychosocial Evaluation	☐ initials	Educational Information
☐ initials	Psychological Evaluation	☐ initials	Discharge/Transfer Summary
☐ initials	Psychiatric Evaluation	☐ initials	Continuing Care Plan
☐ initials	Treatment Plan/Summary	☐ initials	Treatment Progress
☐ initials	Current Treatment Update	☐ initials	Demographic Information
☐ initials	Medication Management	☐ initials	Psychotherapy Notes
☐ initials	Other: _____		

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date: _____

Conditions: I further understand that Jim Cosenza, LCSW, CADC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

_____

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, 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.

Redisclosure: Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

Signature of Patient or Legally Authorized Patient Representative	**Date**
Relationship to Patient	
Jim Cosenza, LCSW, CADC	**Date**