CONSENT TO RELEASE RECORDS

Client Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

This consent authorizes Monica L. Urbaniak, LMFT-S to:

❒ release information regarding the above-named client to

❒ receive information regarding the above-named client from

Name: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

The information below will be disclosed/requested:

❒ Entire Record ❒ Initial Assessments & Final Diagnoses ❒ Psychotherapy Notes

❒ Dates/times/attendance at appointments, general themes, and contact information

❒ Other: _____

The purpose of this disclosure/request is: ❒ Coordination of Care ❒ Treatment Planning

❒ Other _____

This consent may be revoked at any time by providing written notice. By signing this form, the client acknowledges that they been given information about what is to be disclosed/requested, the purpose of this disclosure/request, and who will receive this information. Signing of this form by the client also releases Monica L. Urbaniak, LMFT-S from any legal liability resulting from the release of this information. Consent to this disclosure will expire in eighteen months from the date signed unless otherwise designated below.

_____ _____

Signature Date

_____ _____

Monica L. Urbaniak, LMFT-S Date