

Release of Information

Jemese LaChel Psychotherapy & Coaching, LLC

Jemese LaChel Edmonson, MSW, LCSW
PO Box 10102, Columbia, MO 65205

Office Phone: (573) 427-2992
Fax: (573) 875-8659

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Client Name: _____

Date of Birth: _____

I, _____ hereby authorize Jemese LaChel Psychotherapy & Coaching, LLC / Jemese Edmonson, MSW, LCSW to release and receive information from the below named persons and / or organizations with regard to services provided.

Person(s) or organization to receive and / or release: _____
address: _____ Phone: _____ Fax: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> All Available Records | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Substance Abuse Evaluation |
| <input type="checkbox"/> Verbal Report of Progress | <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> Initial/ Admission Assessment | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Emergency Service Information |
| <input type="checkbox"/> Medication History | <input type="checkbox"/> Medical Records | |
| <input type="checkbox"/> Other _____ | | |

Purpose of information exchange is to facilitate client's treatment. Client agrees to a mutual exchange of verbal, written and/or electronic information between the above named person(s) and / or organization and Jemese LaChel Psychotherapy & Coaching, LLC / Jemese LaChel Edmonson, MSW, LCSW.

I understand the contents to be released, the need for this information and that there are statues and regulations protecting the confidentiality of this information.

I understand that I may give or withhold the consent at my discretion.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2), and may not be disclosed without my written consent unless otherwise provided for in the regulation.

I understand that treatment may not be denied if I refuse to sign this authorization.

I hereby acknowledge my voluntary consent. I understand that I may revoke this consent at any point in time, except to the extent that action based on this consent has already been taken.

Consent expiration date: _____

Signature of Client or Guardian

Date

Witness

Date