# *Release of Information*


Jemese LaChel Psychotherapy & Coaching, LLC

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## 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: Spectrum Health Care
address: 1123 Wilkes Blvd, Ste 250, Columbia, MO, 65201 Phone: 573-875-8687 Fax: 573-875-8659

__All Available Records
__Verbal Report of Progress
__Initial/ Admission Assessment
__Psychological Evaluation
__Medication History
__Progress Notes
__Treatment Summary
__Diagnosis
__Psychiatric Evaluation
__Medical Records
__Substance Abuse Evaluation
__Substance Abuse Treatment
__Discharge Summary
__Emergency Service Information
__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