Robin Gustine Parenting Coach

CONSENT TO RELEASE OF INFORMATION

Communication between healthcare providers and/or among family members is important to help ensure that you receive comprehensive and quality care; however, your information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and/or medication history. You may revoke this consent at any time, except to the extent that action has already been taken in reliance upon it. In any event, this consent shall expire one (1) year from the date of signature, unless another date is specified.

I, _____, for the purpose of coordinating care, authorize
(Client Name)

_____ to release information indicated below
(Provider Name)

TO: _____. Please also indicate if it is permissible for the
(Recipient Name)
information to be exchanged by the above parties in reverse. Yes No

Please indicate the information you authorize for release to the above named party:

- ☐ Any applicable mental health/substance abuse information
- ☐ Only medical information
- ☐ Other: _____
- ☐ None

I/we have read and understand the above information and give my/our consent.

_____ _____

Client or Parent/Guardian Signature (if under 18) Date

25152 Elk Lick Road, Suite 220, South Riding, VA 20152
www.RobinGustine.com