Ephesians Professional Counseling

Dr Sheila Cuomo, EdD, LCPC

State Licensed Clinical Professional Counselor, Doctor of Education

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http://ephesians.org

Consent to Release Clinical Information

Client:_____ DOB:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell:_____

I hereby authorize the release of the following clinical information about me (or about my child or ward) TO and/or FROM Dr. Sheila Cuomo, EdD, LCPC by verbal or written means. **E-mailing clinical information is prohibited**.

____Insurance Verification

____Psychiatric Evaluation

____Psychological Evaluation

____Social History

____Educational Diagnosis

____Academic Records

____Admission/Discharge Summaries

____Summary of Progress

____Laboratory Reports

____Legal Records

____Medications/Changes

____Discharge Plan & medications on discharge

____Other (specify)_____

Organization or person with whom Dr. Sheila Cuomo, LCPC will communicate:

Agency Name:_____

Contact Person: _____

Address: _____

_____

Phone:_____ Fax:_____

• I understand that Dr. Sheila Cuomo, EdD, LCPC cannot be held responsible for re-disclosure of protected health information once it has been released to another party.

• I understand that I may revoke or terminate this authorization by submitting a written request to Dr. Sheila Cuomo, EdD, LCPC otherwise this authorization will be effective for 2 years from the date of signature.

_____ _____ _____

Signature of Client/Legal Guardian | Relationship to Client (if applicable) | Date

_____ _____

Signature of Therapist | Date