Julia Gerhardt, LCSW, LLC
6550 Emerald St., Suite 110
Boise, ID 83704
(208) 297-8585

Consent to Release Information

I, _____, hereby consent that Julia Gerhardt, LCSW, LLC (circle all that apply): (*release information to*) (*obtain information from*) or (*exchange information with*):

Name: _____

Agency/Address: _____

Phone Number: _____ Fax Number: _____

I request the following checked types of communication to be released/obtained/exchanged:

_____diagnostic evaluation _____probation/parole records

_____social history _____treatment plan

_____school records _____psychological testing

_____progress notes _____ongoing telephone consult

_____other_____ _____other_____

Please specify if you wish limitations on information to be released: _____

Unless I direct Julia Gerhardt, LCSW, LLC otherwise, I authorize the released information to be conveyed to the requesting party using any reasonable method under the circumstances, including, without limitation, facsimile, electronic messaging, standard or regular mail, or courier.

It has been explained to me the specific type of information requested as well as the benefits and disadvantages of releasing the information, if known. Also, I have been informed that treatment services are not contingent on my decision concerning this release. I also understand that information used or disclosed in accordance with this authorization may no longer be protected by Federal Law, and could be used or re-disclosed by the receiving party.

I have carefully read and understood the foregoing. I voluntarily consent to the release of the above specified information about or medical records of my condition and the treatment and services I have received in the course of my diagnosis and treatment to those persons or agencies listed. I further release my attending clinician and associated from any liability arising from the release of this information or records to such designated persons or agencies. This consent is subject to revocation at any time and unless otherwise specified expires six years after signing.

Client signature: _____ Date: _____

Witness: _____ Parent or Guardian: _____

Note to Agency/Person in Receipt of Information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.