David Levingston, M.A., LMFT
Licensed Marriage and Family Therapist LMFT 100-0000054
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Consent to Release Confidential Information

[If you wish to grant permission for therapist to share any info with a 3rd party]

I, (Client name) _____, D.O.B. _____

do hearby authorize:

David Levingston, M.A., LMFT,

to receive from, release to, or exchange with:

_____
Name/Agency

_____
Address/Phone Number

The following information:

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

_____

For the purpose of:

Client Initial *(Check all that apply):*

_____ ☐ The development of a treatment / service plan
_____ ☐ Coordination of care w/ family/behavioral health or medical providers
_____ ☐ Ongoing treatment / continuing care
_____ ☐ Insurance or employment
_____ ☐ Other (Specify): _____

I understand that information disclosed above is protected by Federal Regulation 42CFR, Part 2, and cannot be released without my written consent unless otherwise required by law. I understand that I need not consent to the disclosure of information in order to obtain treatment services. I choose to do so willingly and voluntarily for the purposes specified above. The duration of this authorization is no longer than one year unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying David Levingston in writing, except to the extent that action has been taken in good faith on my consent.

Client Signature _____ Date _____

Parent/Guardian/Legal Representative Signature _____ Date _____

THIS CONSENT WILL AUTOMATICALLY EXPIRE IN ONE YEAR or as specified _____