LINDSAY SORENSEN, M.S., LPC, LCDC

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CONSENT FOR RELEASE OF INFORMATION

I, _____, give Lindsay Sorensen with Lindsay Sorensen Counseling, PLLC, permission to release and obtain my protected treatment information to and from the following person or agency:

Name of person or agency: _____

Relation: _____ Phone number: _____

Address:_____

Email: _____

Information may be shared via- Circle applicable method, or circle ALL METHODS*:

Phone Fax Postal service Email In person

** I understand none of these methods are totally confidential and are susceptible to breaches in confidentiality.*

Information to be obtained and released- Circle applicable, or circle FULL CONSENT:

Treatment plan Discharge summary Progress notes Diagnosis Billing information

Substance use information General wellbeing Progress of treatment

Other: _____

Purpose for obtaining and releasing information- Circle applicable:

Progress reporting Reimbursement Legal Continuity of care Other: _____

Please *initial* the following:

_____ I understand that this release is limited to what I have written above. If I would like Lindsay to release information about me to anyone else, I will need to sign another written release.

_____ I understand that Lindsay is not able to control what happens to my information once it has been released to the recipient identified above, and that the agency or person receiving my information may be required by law or practice to share it with others.

_____ I understand that this release expires one calendar year from the date noted below.

I understand that this release is valid when I sign it, and that I may withdraw my consent to this release in writing at any time.

✤_____ _____

Client Signature (or Parent/Guardian if Client is a Minor) Date