Inclusivity Clinical Consulting Services

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info@inclusivityconsulting.com Website: http://inclusivityconsulting.com/

Authorization to Release Information

I, _____, the undersigned, give permission to Inclusivity Clinical Consulting Services (ICCS) to release and provide to:

_____ (Name)
_____ (Address)
_____ (Phone Number)

the following information (check all that apply)

☐ my attendance in therapy
☐ my diagnosis
☐ my treatment plan
☐ information relevant to coordinating care
☐ when treatment is terminated and why
☐ other (please explain in detail)

_____

I understand that that this release is valid for ☐ a period of 120 days, or, ☐ until the need for such disclosure no longer exists. I further understand that I may revoke this authorization at any time in writing.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

_____ Signature
_____Date