ROI: RELEASE OF INFORMATION CONSENT

Teagan Darnell, MA, Marriage and Family Therapist LMFT # 93748
www.teagandarnelltherapy.com
(925) 939-6338

If you would like me to consult with another professional about therapeutic treatment please complete this form. If there is no one that you would like me to consult with at this time, you may leave this form blank.

By signing this document I hereby authorize Teagan Darnell, MA, Marriage and Family Therapist LMFT # 93748 to disclose information and records obtained in the course of my treatment to the person identified below:

Professional's Full Name: ____

Phone: ____

Email: ____

This disclosure of information and records authorized shall include the following specific types of information about:

- *Psychiatrist Consultation*
- *Medications*
- *Treatment Plan*
- *Referral for Tx*
- *Old/New Therapist Consultation*
- *Inpatient/Outpatient Tx*
- *Insurance Reimbursement*
- *Subpoena*
- *Parent/Guardian Consultation*
- *Teacher Consultation*

*Other:*____

____

This authorization will remain valid until termination of therapeutic treatment. *If you would like to set another date for this release to expire please specify it here, otherwise leave this space blank:*

____

** I understand that I have a right to receive a copy of this authorization upon request. I also understand that any cancellation or modification of this authorization must be in writing. I understand that a photocopy or facsimile of this authorization will be regarded with the same authority as an original.*

Signature(s)

____Date_________

Print Name:

____Date_________

Reference: California Civil Code Section 56.11