JANE C PATTERSON, MSW, LCSW

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CONSENT FOR RELEASE OF MENTAL HEALTH INFORMATION

Patient Name: ________________________ **Date of Birth:**__________________________

Therapist:

________ Jane C. Patterson, LCSW

________ In order to insure coordination of care and to provide quality care, I authorize my therapist to consult with, and release information concerning my care to, my primary care physician. I understand that these records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. My consent may be revoked at any time.

________ I decline the release of treatment information to my primary care physician.

Physician: ____

Address: ____

____ ________________________
Signature of Patient or Legal Guardian Date

____
Relationship to Patient

____ ________________________
Witness Date