Marti F-Mowers,Ed.D.,LCSW,LMFT,E.T.(P/A/M),E.I.S.>S
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CONSENT FOR RELEASE FOR INFORMATION

Name: _____

Date of Birth: _____ Contract Number: _____

Check all that apply: **ONLY INFO CHECKED BELOW IS APPROVED FOR RELEASE**
Extent or nature of information to be disclosed: ☒ Mental Health ☒ Alcohol/Drug ☒ CMedical

☒ Assessment / Evaluation ☒ Discharge Summary ☒ Treatment Plan / Recommendations

☒Medical Assessment ☒Progress Notes ☒Diagnosis ☒ Educational Testing

☐Conversation and Written Dialogue ☐ Update Reports ☐ Other_____
Permission is given to Marti Fausold-Mowers,Ed.D.,LCSW
to share information with and receive information from:
Purpose or need for disclosure:
☒Continuity of Care ☒Evaluation ☒Treatment Planning
☐Other: _____

I, the undersigned, have read the above and authorize the practitioner named above to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I understand, in the case of releasing substance abuse information, that any disclosure is bound by Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records. I understand, in the case of releasing HIV related information, that any information which could indicate that a person has been potentially exposed to HIV related illness of AIDS, or any information which could indicate that a person has been potentially exposed to HIV under New York State law can only be released to persons you allow to have it by signing a release. I understand that if I sign this form, HIV related information could be given to the people listed on the form for the reason(s) listed on the form. If I experience discrimination because of release of HIV related information I may contact the New York State Division of Human Rights at (212)870-8624 or the New York City Commission of Human Rights at (212)566-5493. Any redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: _____

_____ _____
Patient's Signature (if over 16) / Date Signature of Parent / Guardian Date

Name of Parent / Guardian

I hereby cancel my authorization to release the information outlined on this form:

_____