Elizabeth J. Gomart, LPC
Psychotherapy
Individual Couple Group

Release of Information

Today's Date: _____

Patient name:_____ **DOB:**_____

I, _____ (Patient Name), authorize Elizabeth J. Gomart, LPC

_____ to Disclose and/ or _____ to obtain information about me/ Patient:

from (full Name)_____

Relationship to patient:_____

Address: _____

City: _____State:_____Zip:_____

Phone number:_____Email:_____

In the following manner: ___Electronic ____Oral ____Written

Information pertaining to:

[ ] Presence in treatment [ ] Progress in treatment [ ] Assessment

[ ] Psychiatric history [ ] Treatment plans [ ] Discharge planning

[ ] Family info [ ] lab test results [ ] physical exam

[ ]Current medical status [ ] Medical history [ ] Employment info

[ ] Legal status [ ] other legal issues

[ ] other_____

I understand my records are protected under HIPPA and may not be disclosed without my written consent unless otherwise provided for in the regulations.I also understand that I may revoke this consent at any time. The expiration date for this consent form is_____.

_____ _____

Client signature Date

I have explained and/or read this Consent to Release information to the patient.

_____ _____

Elizabeth Gomart, LPC Date