PATIENT'S/CLIENT'S INFORMED CONSENT

I, ____________ authorize **Sylvia Rosenfeld LCSW**, to provide clinical services to me/my child/my family. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material will be discussed which will be upsetting in nature and that this may be necessary to resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state law regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be circumstances in which the law requires my therapist to disclose confidential information.

I understand that in the event that cancellation becomes necessary, I must give my therapist forty-eight (48) hour notice in order to not be billed for that time.

I have read and understand the above.

_________________________________ _____________________
Signature of Patient/Client Date

_________________________________ _____________________
Signature of Parent, Guardian, or Authorized Representative Date

_________________________________ _____________________
Signature of Witness Date

AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

I, , SS# ____________________, hereby give permission to

__________________________________ at _______________________________________to:

O Disclose information to: AND/OR O Obtain records from:

____,
(Name of agency, school counselor, attorney, therapist, etc.)

____.
(Address, city, state and zip code)

Phone: ____________________ Fax: ________________________

Extent or Nature of Information to be Disclosed:

O Psychiatric evaluation and treatment records
O Psychiatric hospitalization summaries
O Psychological evaluation/Treatment records
O Substance abuse evaluation from school
O Other (specify):_______________________________________
O Speech evaluations/treatment records
O Medical or pediatric evaluation/ treatment record
O Neurological evaluation/treatment records
O Academic testing reports or records

Purpose or Need for Information

O Psychiatric evaluation and treatment
O Psychological treatment/planning
O Other (specify): _______________________________________

I hereby authorize the periodic release of the above information to the person/facility/program identified above as often as necessary to plan for/provide care and treatment. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

My consent to release information to the person/organization/facility/program identified above, will expire when I am no longer receiving services from such person/organization/facility/program, or One year from this date, whichever occurs first.

______________________________ ___________________
Signature of Patient/Client Date

______________________________ ____________________
Signature of Parent or Authorized Representative Date

______________________________ _____________________
Signature of Witness Date

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.