Beth Linfoot, Counseling, PLLC
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Consent for Release of Information

Communication between your primary care physician (PCP), your psychiatrist and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow Beth Linfoot, LPC to share protected health information (PHI) with your other providers and or your child's providers and school staff. This information will not be released without your signed authorization. This PHI may include medical and psychiatric assessments, treatment plans, medication, psychological evaluation, clinical impressions, summary notes, school information, and any other relevant information regarding your, or your child's mental health.

Patient Rights

You may end this authorization at any time by contacting my office.

If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.

You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.

You have a right to a copy of this signed authorization.

If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization
I hereby authorize Beth Linfoot, LPC to release and/or receive verbally or in writing information regarding any medical, mental health, and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any
actions taken before the provider receives the request.

Beth Linfoot, LPC is authorized to release and/or receive protected health information related to the evaluation and treatment of _____ (Patient Name)

DOB: _____.

PCP Name:
_____
PCP Address:
_____

(Street) (City) (State) (Zip Code)

PCP Phone: _____

Psychiatrist Name:
_____

Psychiatrist Address:
_____
(Street) (City) (State) (Zip Code)

Psychiatrist Phone: _____

Other Name:
_____
Other Address:
_____
(Street) (City) (State) (Zip Code)
Other Phone: _____ Other Fax:
_____

____ ***I hereby decline to give authorization for any release of information.***

Signature _____
____I am the patient. ____I am the parent. ____ I am the legal guardian.

Printed Name: _____
Date:_____

Relationship of signer (if not patient):

_____