Colleen A Tredway, MA, LMHC
1611 Santa Barbara Blvd., Suite 160
Cape Coral, FL 33991
(239) 677-8921 (Phone)

Authorization to Release/Obtain Mental Health Information

Date: _____/_____/_____

Patient Name: _____

Date of Birth: _____/_____/_____ **Social Security Number**: _____-_____-_____

I hereby authorize **Colleen Tredway, MA, Licensed Mental Health Counselor** to ( ) disclose and/or ( ) request information to/from (specify name, address, fax number if applicable):

_____
_____
_____

Method of Disclosure: ____Verbal ____Written
Purpose of Disclosure: ____Coordination of Care ____Legal Matter
____Other:_____

Information to be Disclosed/Requested:

____Clinical Assessment	____Diagnosis
____Treatment Recommendations	____Treatment Progress/Discharge
____Psychiatric/Psychological Evaluation	____Psychological Testing
____Medication History/Evaluation	____Progress Notes
____Academic Records	____Court Records/Documents
____Medical History/Physical	____Laboratory Results

____Other: _____

I expressly authorize information concerning the following to be released:
____Drug/alcohol treatment/abuse ____HIV/AIDS/ARC ____Mental Health Treatment

Notice to recipients receiving drug/alcohol abuse treatment records:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit 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 the 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/drug abuse patient.

I understand that this authorization will remain in effect for one year from today's date_____. I understand that if Colleen A Tredway, MA, LMHC is requesting the authorization for her own use, it will not condition the treatment, payment, enrollment in a health plan, or eligibility of benefits on my providing authorization for the requested use of disclosure.

I understand that I may request a copy of this signed authorization. A photocopy of this release is valid to the same extent as an original. I further understand that I may refuse to sign the authorization. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law. I understand that I can, at any time, change my decision and revoke my authorization, in writing, for releasing/requesting information as noted on this form.

_____ _____/_____/_____
Client Signature Date

_____ _____/_____/_____
Legal Representative (If Necessary) Date

_____ _____/_____/_____
Colleen Tredway, MA, LMHC Date