



Information to be disclosed is **limited** to:

\_\_\_ Attendance Records

\_\_\_ Treatment Summary

\_\_\_ Diagnosis

\_\_\_ Treatment Planning

\_\_\_ Billing Record

\_\_\_ Discharge Summary

\_\_\_ Treatment Plan

\_\_\_ Re-admission Recommendations

**I understand:**

- That I do not have to sign a release form nor am I obligated to release my information.
- Signing a release form is completely voluntary.
- This release is limited to what I write above. If I would like to release information in the future, I will need to sign another written, time-limited release.
- That information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- That Jennifer Walrod, LCSW, and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.
- My refusal to sign this release form will not jeopardize my right to obtain present or future treatment for mental health treatment.
- I may request a signed copy of this form.

*Expiration should not exceed six months.*

**This release expires on** \_\_\_\_\_  
Date

**I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 DFS, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information is not sufficient for this purpose.