Lynette Ingram Cassel, ATR, LMHC

Request/Authorization to Release Confidential Records and Information

I hereby authorize:
Person or facility _____

Address_____

_____

Phone: _____ Email _____

to release information from records about:

(Client name) _____Date of Birth _____

to Lynette Ingram Cassel, ATR, LMHC, 259 Massachusetts Avenue Arlington, MA 02464, 617-855-5749

for the following purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Coordination of treatment
❑ Treatment planning ❑ Other: _____

These records concern the time between _____ and _____.
The following information from my records may be disclosed:

- ❑ All General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
- ❑ Psychotherapy Notes
- ❑ Verbal Exchange of Protected Health Information
- ❑ Educational Records
- ❑ Other: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically upon discontinuation of services with Lynette Ingram Cassel, or upon fulfillment of the purposes stated above.

_____

Signature of client Printed name Date

_____

Signature of parent/guardian Printed name Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ Lynette Ingram Cassel _____

Signature of Witness Printed name Date