Consent for Release of Information

F. Sean Redeker MA, LPC, CI, NCC

Instructions: Complete the form, print 2 copies, and sign both. Keep a copy for your records.

Social Security Number	Name: Last	First	Middle
- -			

Address: Street	City	State	Zip

Phone Number:	Cellular Number:	Birth Date:	Age
- -	- -	/ /	

This consent authorizes F. Sean Redeker, MA, LPC, CI, NCC

☐ To release information regarding the above name patient to:	☐ To release information regarding the above name from:

Name:	Organization:

Address: Street	City	State	Zip

Phone Number:	Fax Number:
- -	- -

Record Type:

☐ Entire Record	☐ Assessments	☐ Progress Note	☐ Drug\Alcohol
☐ Hospital Notes and Discharge Summary		☐ HIV/AIDS	☐ Current Medications
☐ Other			

This purpose of this disclosure request is:

☐ Coordination of Care	☐ Treatment Plan
☐ Other	

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This consent may be revoked at any time by providing written notice. By signing this form the patient acknowledges that he \ she has been give information about what is to be disclosed\requested, the purpose of the disclosure\request, and who will receive the information. Signing this form also releases F. Sean Redeker, MA, LPC, CI, NCC from any legal liability resulting from the release of this information. Consent for this disclosure will expire ninety days after termination of treatment with F. Sean Redeker, MA, LPC, CI, NCC. The expiration may otherwise be set at the discretion of the patient for the following date: / /

_____ _____

Client Signature Date

_____ _____

Signature of Parent, Guardian or Representative Date

_____ _____

Signature of Therapist Date