INNERSIGHT
LLC
PRIVATE PRACTICE MENTAL HEALTH COUNSELING

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Innersight LLC, by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Innersight to:

___X__ release to:_____
_____ obtain from:
_____ exchange with:

_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____two way conversations
__X___ other (specify) _____insurance related_____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
__X___ other (specify) _____billing, coverage and chart audits_____

This consent will automatically expire one (1) year after the date of my signature as it appears below.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____

Signature of Client **Date**

_____

Signature of Parent or guardian if under 14 **Date**

_____

Signature of Innersight LLC Representative **Date**