DANIEL GARCES

Masters of Science in Counseling Psychology
Licensed Marriage & Family Therapist
Licensed Professional Counselor

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, ____, authorize Daniel Joseph Garces, MS, LPC, LMFT and ____ to exchange verbal and/or written diagnostic, referral and treatment information about me.

Specific information to be released:

__________ Attendance information
__________ Chemical dependency treatment information
__________ Clinical progress information
__________ Diagnostic information
__________ Discharge information
__________ HIV status information
__________ Insurance information
__________ Medical history information
__________ Name and other identifying information
__________ Psychiatric information
__________ Referral information
__________ Other (specify): _______________________
____

The purpose of this exchange is to:

__________ Facilitate care __________ Insurance requirement __________ Probation / Parole requirement
__________ Other (specify):____

I understand that my records and information are considered to be highly confidential and are protected under federal, state and local laws, rules and regulations as well as codes of ethics governing the practice of counseling and psychotherapy and cannot be disclosed without my written consent.

I hereby give my written consent to Daniel Joseph Garces, MS, LPC, LMFT to disclose the information indicated above for the purposes noted above. I understand that this consent expires 6 months after my last date of service and that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.). I further understand that once I release information to the party listed above that Daniel Joseph Garces, MS, LPC, LMFT can not ensure the confidentiality of that released material. A photographic copy of this authorization shall be considered as valid as the original.

____ _______________________
Signature of client Date

____ ____
Signature of parent, guardian or authorized representative Signature of therapist

I hereby revoke my consent as of this date. I understand that all records and information sent prior to this revoke were sent at my request. By signing this revoke, I request that Daniel Joseph Garces, MS, LPC, LMFT send no further records, information or communicate with the party listed above regarding me and/or my case.

____ _______________________
Signature of client Date

____ ____
Signature of parent, guardian or authorized representative Signature of therapist

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