VANGUARD
MENTAL HEALTH & WELLNESS CLINIC, LLC

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CONSENT FOR RELEASE OF ALL PSYCHOTHERAPY RECORDS

I consent to and authorize Vanguard Mental Health & Wellness Clinic, LLC (Vanguard Clinic) to release ALL psychotherapy records in Vanguard Clinic's health records pertaining to my behavioral and mental health care to the following agency/individual:

TO RELEASE ALL PSYCHOTHERAPY NOTES TO:

_____

_____

_____

I understand that the information being exchanged may include behavioral or mental health functioning, information regarding all types of abuse and information regarding treatment for alcohol and drug abuse. Even with this understanding, by signing below, I am acknowledging full understanding of this and any risks involved in releasing all records. I also do not hold Vanguard Clinic liable or responsible for the content of these records.

This authorization will expire in one year, unless it is revoked.

I understand that I have a right to stop this authorization at any time. If I stop this authorization, I must do so in writing to Vanguard Clinic. I understand that stopping this authorization will not apply to information that has already been released or disclosed for purposes of treatment, payment, and care operations.

I understand that signing the release of my records is voluntary. I can refuse to sign this authorization. It is not necessary for me to sign this from in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

My signature here means I have read this information and understand it.

Signature: _____ Date: _____

Print name: _____
Relationship to patient: _____

Interpreter (name/signature): _____

Patient Name: _____
Date of birth: _____