Office of Eric Cuestas-Thompson, LICSW

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Consent To Obtain or Release Confidential Information

Client Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (HM) _____ (WK) _____ Date of Birth: _____

I. _____, authorize Eric Cuestas-Thompson, LICSW to: (please mark all that apply)

- ◎ **OBTAIN**
- ◎ **RELEASE**

medical, psychological, educational, legal and social information pertaining to the above-mentioned individual.

Person / Agency / Institution, from or for who records are to be obtained / released.

Name: _____
Phone Number: _____
Address: _____
Purpose of obtaining / releasing information:
_____
_____
_____

Information to be obtained / released:

- ☐ **Assessment Information**
- ☐ **Treatment Plan(s)**
- ☐ **Progress Notes**
- ☐ **Treatment Summary**
- ☐ **Discharge Summary**
- ☐ **Other:**

This release shall be effective for one year, until the _____ day of _____, 20____.

Eric Cuestas-Thompson is hereby released from any and all legal liability that may arise from the obtention or release of information requested. I certify that this request for obtention or release has been made freely and voluntarily. I understand that I may revoke this authorization at any time, except that action has already been taken on the consent.

I understand that my records are protected under federal regulations 42 CFR Part 2, governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I ma revoke this consent at any time except to the extend that action has been taken in reliance on it, and that in any event this consent expires automatically in one year from the time this form is signed.

_____	_____	_____
Client Name	Client Signature	Date
•		
•_____	_____	_____
•Parent or Guardian (if applicable)	Signature	Date
•		
•_____	_____	_____
•Witness	Signature	Date