Teri Ehlers, LAMFT
teriehlersmft@gmail.com
(480) 234-3461
Postpartum and Relationship Counseling, LLC
3200 N Dobson, St. D4, Chandler, AZ 85224

Consent for Release of Information

Patient Name_____ Date _____

I hereby authorize Teri Ehlers, LAMFT, Postpartum And Relationship Counseling, LLC ( ) to receive ( ) to release records, and information obtained in the course of the diagnosis and treatment of the above named patient for mental health purposes to/from:

Name of Individual & Credentials/Agency/Facility

Phone Fax

Address City Zip Code

This authorization releases Teri Ehlers, LAMFT, Postpartum and Relationship Counseling, LLC, from any legal responsibility or liability for the disclosure of the following information to the extend indicated and authorized herein. In accordance with Federal Regulations 42 CFR Part 2, I hereby consent to release of records pertaining to Treatment/Diagnosis of the following: (If patient is a minor and information is to be released regarding treatment for alcohol or substance abuse, both the patient and the parent or guardian must sign).

____ Conditions related to substance and/ or alcohol abuse

____ Conditions related to psychological treatment

____ Intake evaluation, diagnosis and recommendations

____ Progress notes, staffing notes, group notes

____ Other _____

____ No need to send records – 2 way phone conversation only for items marked above.

The above information is requested for the purpose of coordination of treatment and continuity of care.

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose, this consent with automatically expire one (1) years following date of signature without my expressed revocation. I understand that the release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written authorization must be obtained for a proposed new use of information or for its transfer to another person or entity. I understand that I have the right to a receive a copy of this release upon request.

_____ _____
Signature of Client (Parent or Guardian of Minor) Date

_____ _____
Signature of LAMFT Date