INSTITUTE FOR
PRACTICAL LIFE
"your place for psychotherapy and wellness"

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RELEASE OF INFORMATION

DATE:

*Release of Information **MUST BE SIGNED** if you are using your insurance company to cover your sessions.*

Patient's Name:

DOB (mm/dd/yyyy):

Authorization to Release and Obtain Information

I, , hereby authorize the release to obtain from and exchange with information specified below:

- ☐ COMPLETE RECORD
- ☐ Response to treatment
- ☐ Progress Notes
- ☐ Assessment
- ☐ Social or Family History
- ☐ Recommendations
- ☐ Diagnosis
- ☐ Prognosis
- ☐ Educational Evaluation
- ☐ Treatment Plan
- ☐ Medication Management
- ☐ Demographic Information
- ☐ Summary of Treatment
- ☐ Transition Summary
- ☐ Other

To: Release to, or request, with the purpose of coordination of care or ongoing evaluation from:
Insurance Company / Primary Care Physician / Lawyer / Employer / Parents / Partener / etc

Name:

Address:

Phone:

Fax number:

I understand that this directive is subject to revocation at any time upon my written request.

Otherwise this consent will expire upon termination of services.

I herewith release and hold harmless.

Institute for Practical Life (732-610-5119) Service Provider.

In the absence of my handwritten signature, I understand that my typewritten name serves as a written signature for the purposes of this application.

Patient signature/full name and date:

Parent/guardian signature/full name and date:

Witness/clinician signature/full name and date: