JGC
CONSULTATIONS

Consent to Release Protected Health Information

If we discussed your previous treatment in session, please complete a release of information so that I may contact your previous provider(s)

Please only include ONE party per authorization. Print out separate authorization forms for each party invited into this agreement.

Patient Name: _____

I authorize Dr. Justin Capote to discuss and share confidential information about my treatment with the parties listed below and vice versa. This confidential information includes, but is not limited to, my history of psychotherapy and psychotropic medication use, my medical and family histories, my history of drug and alcohol use, my legal and financial status, the results of diagnostic testing, my clinical progress and planned or possible treatment interventions, and any other information deemed important by Dr. Capote to assist with my treatment and/or other personal or business matters requested including, but not limited to, insurance reimbursement, legal action, regulatory action, marital conflict, or child custody.

Please include the full name, address, and telephone number for the parties identified in this authorization. Parties may include your previous psychiatrist or psychotherapist, primary medical doctor, medical specialists, family members, caseworker, attorney, etc.

Name: _____

Address: _____

Telephone or other preferred method of contact: _____

I acknowledge that this consent can be revoked by me in writing at any time, and that I can do so for any reason except to the extent that: (a) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; (b) disclosure has already occurred, (c) any pending action already taken and/or in progress that relies on this disclosure.

Patient Signature: _____ Date: _____