

**CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, do hereby consent to authorize:  
(Client Name, DOB)

Margaret (Peg) Haust-Arliss, LCSW-R

**TO OBTAIN AND RELEASE TO:**

\_\_\_\_\_  
(Name of Person or Facility)

\_\_\_\_\_  
(Address and Phone Number)

The following information:

- \_\_\_\_ Presence in treatment (including admission and discharge dates)
- \_\_\_\_ Diagnosis, recommendations, brief description of progress in treatment
- \_\_\_\_ Medical and physical history
- \_\_\_\_ Intake Assessment/Psychosocial Evaluation Results
- \_\_\_\_ Treatment Plan (problem identification, goals, strengths)
- \_\_\_\_ Discharge Summary
- \_\_\_\_ Aftercare Plan
- \_\_\_\_ Other information pertinent to case management: \_\_\_\_\_

The information is needed for the following purpose(s):

- \_\_\_\_ To provide ongoing communication with referring agency
- \_\_\_\_ To provide ongoing treatment/services
- \_\_\_\_ To obtain insurance, employment or government benefits
- \_\_\_\_ To enable judges and attorneys to support treatment goals
- \_\_\_\_ To coordinate treatment efforts with my family/concerned persons
- \_\_\_\_ To coordinate treatment and aftercare efforts with my employer
- \_\_\_\_ Other: \_\_\_\_\_

I understand that only the minimum amount of health information necessary to achieve the purposes of the disclosure will be released.

I understand that I can revoke this authorization in writing at any time, except to the extent that action was already taken based upon the original authorization. Unless otherwise revoked, this authorization will expire 6 months from the date of ending treatment with provider.

I understand that Margaret Haust-Arliss cannot condition my continued or future treatment on whether I provide authorization for the requested use or disclosure, and that I can refuse to sign this authorization, but that in certain limited circumstances, I may be denied treatment if I do not sign this consent form.

I understand that information used or disclosed as a result of this signed document may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law.

\_\_\_\_\_  
(Signature of Client)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent/Guardian/Legal Rep.)

\_\_\_\_\_  
(Date)