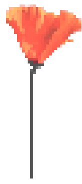

Optimal Behavioral Health PLLC
Phone: (360) 389-2042
optimalbehavioralhealth@gmail.com

Client:____Date of Birth:___________

I authorize Optimal Behavioral Health PLLC, Britt I. Elsing LMHC, MHP to exchange or release the following information to facilitate informed services and continuity of care:

Previous Treatment Records _____
Psychological Evaluation Results_____
Appointment Scheduling_____
Medical Information_____
Progress in Treatment_____
Mental Health____
Medication Management_____
Financial/Billing Information____

With:
Name of Person/Relationship: ____

Organization:____

Street:____

City/State/Zip:____

Phone: ___________________________ Fax:______________________________

- I understand that this consent expires 30 Days after termination of treatment.

- I understand that records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems are protected under federal confidentiality regulations (42 CFR, Part 2–Alcohol and Drug) and cannot be disclosed without my written consent. I also consent to the release of that information. ________________ (client initials)

- Other parties receiving this information are prohibited from disclosing these records unless expressly permitted by my written consent, unless disclosure is otherwise permitted by federal regulations.

- I understand that I can terminate this consent at any time in writing.

____

Client/Parent/Guardian Signature Date

This form will be retained in the mental health record