Debbie Bensching

Clinical Social Worker

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, ____ authorize Debbie Bensching, LCSW, to release/obtain the following information about me: ___ Psychological and/or alcohol abuse treatment records, ____ Psychological or psychiatric evaluations, reports, assessments, treatment notes, summaries, or other diagnostic documents, ___ Social, Family, educational, and vocational histories, ___ Information about patients condition, to work, ___ Billing records, ___ HIV-related information and drug and alcohol information contain in these records will be released in these records unless indicated here: ___ do not release. ___ Other: ______________ ______________________________
____
____

To/From: (name)____
(address)____(phone)________________

For the purpose of: ___ coordination of care ___ treatment planning ___ consultation
___ other : ____

I understand that my records/ are protected under confidential regulations and laws. They cannot be disclosed without my written consent except for the specific exceptions described in the Office Policies and Informed Consent statement. I also understand this consent may be revoked in writing at any time. Any information disclosed prior to a written revocation is valid under this consent form. Otherwise, this authorization will expire: ____

Client Signature: ____Date: ___________

Client Signature: ____Date: ___________

Witnessed by: ____Date: ___________