APOGEE
Human Services Consultants, LLC
Reach Beyond Limits.

CONSENT TO RELEASE

PSYCHIATRIC/ MEDICAL and/or ALCOHOL/DRUG ABUSE RECORDS

I, _____, BIRTH DATE ____/____/____,hereby authorize Sheila LeGrand, LMHC to have bilateral exchange of information that is contained in my medical record with: _____ under the conditions listed below:

1. This information will be limited to:
   ____ Psychiatric/medical/alcohol/drug abuse evaluation.
   ____ Psychiatric/medical/alcohol/drug abuse discharge summary.
   ____ Progress notes. ____Psychological testing.
   ____ Psychotherapy notes. ____Educational testing.
   ____ Lab studies. ____Other:
   ____ Medical tests/studies. ____Other:

2. Purpose or need for such disclosure:
   _____ Continuing care/Treatment,
   and/or _____.

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon _____.
   (Specific Date, Event or Condition)

4. An additional consent must be obtained for any other transfer or disclosure of this information.

5. I understand that I may receive a copy of this release.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent, Guardian or other Person authorized by law to sign in lieu of Patient (where required). Indicate which. Date

_____ _____
Witness (if applicable) Date