

**Anne Chester, LCSW, PA
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-7884**

Patient Information and Demographics Form

Date: _____ Referred By _____

Patient Full Legal Name: _____

Preferred Nick Name: _____ Gender: M F

Place of Employment _____

Employers address _____

Social Security # _____ Date of Birth _____

Insurance Type: _____ Card Number _____

Name of insured if different _____

Insured's Date of Birth (if different from patient) _____

Phone Number to Insurance Company: _____ Policy Number: _____

Name of Insured: _____

Home Phone Number: _____ Other Phone Number: _____

Address: _____

What is your marital status? _____ If divorced or widowed, when did this occur? _____

Who do you live with? _____

Describe you living environment? _____

Why are you seeking treatment today? _____

Are your parents living? _____ Describe you relationship with them: _____

Medical History:

Please list any prescription medications you currently take, (name dosage, frequency):

Please list any over the counter medications you currently take (name, dosage, frequency):

Please list any past or present conditions for which you have been treated: _____

When did you have your last physical examination? _____

Were any medical issues identified during this exam? If yes, please specify. _____

Please describe any medical, psychiatric, or addiction conditions/issues of your parents or siblings:

Patient's Habits	Amount currently using	Most ever used
Coffee (cups/day)		
Cigarettes / nicotine		
Alcohol		
Non-Prescription drugs		
Illegal Drugs		

Do you attend AA/NA or other 12 step meeting? _____ Have a sponsor? _____

		No	Yes	Some
1.	Do you have problems paying attention to details or do you make careless errors?			
2.	Do you have problems staying on task?			
3.	Are you easily distracted?			
4.	Do you have problems remembering instructions?			
5.	Have difficulty organizing tasks?			
6.	Do you avoid or dislike activities that require sustained mental effort?			
7.	Do you often lose things necessary for tasks?			
8.	Do you have problems sitting for long periods of time (1 hour or more)?			
9.	Are you forgetful of daily activities?			
10.	Do you talk excessively?			
11.	Do you act without thinking?			
12.	Do others say that you interrupt or are intrusive?			
13.	Do you have short fuse?			
14.	Do you have problems with road rage?			
15.	Are you vindictive or spiteful?			
16.	Do you hold grudges?			
17.	Are you easily annoyed?			
18.	When you are angry are you aggressive (hitting, kicking, etc)?			
19.	Have you ever intentionally hurt another person?			
20.	Have you ever intentionally hurt or been cruel to an animal?			
21.	Do you get sad or irritable for no reason?			
22.	Do you have trouble falling asleep?			
23.	Do you have problems staying asleep?			
24.	Do you have recurrent nightmares?			
25.	Are you falling asleep during the day?			
26.	Do you have a loss of energy?			
27.	Have you ever been sad for longer than 2 weeks?			
28.	Do you have mood swings?			
29.	Do you ever feel overly excited or unusually happy for no reason?			
30.	Do you feel and look tired?			
31.	Do you excessively worry?			
32.	Are you concerned about meeting new people?			
33.	Do you worry that bad things might happen?			
34.	Do you worry that others might not like you?			
35.	Do you worry that others are against you?			
36.	Do you feel restless?			
37.	Do you have problems concentrating due to worry?			

		No	Yes	Some
38.	Do you have rituals or routines that you have to do?			
39.	Do you hear or see things that others don't hear or see?			
40.	Are you easily stressed?			

Describe your mood today: _____

Have you ever felt like hurting yourself? _____ If yes, did you or do you currently have a plan? _____

Have you ever been arrested? _____ If yes, please tell me what happened? _____

What was the outcome of your arrest (prison, probation, etc)? _____

Are you currently on probation or parole? _____ For what reason? _____

Have you ever had a DUI or DWI? _____ When? _____

Do you have a religious preference? _____ Do you believe in a higher power? _____

What role does your higher power play in your life? _____

Are you presently employed or in school? _____ What is your occupation? _____

Are you satisfied with your employment/school situation? _____ If no, why? _____

What is your highest level of education? _____

What do you like the most about yourself? _____

Have you ever received psychiatric or psychological treatment of any kind before? _____

If you answered yes to the above question, please answer the following:

What type of care did you receive? Inpatient (hospital) ___ Outpatient ___ Both ___

When and where were you in treatment? _____

How long were you in treatment? _____

What was the diagnosis? _____

Who was your therapist or doctor? _____

Did you receive medication at the time? _____

Did you feel that the treatment was helpful? _____ Why or Why not? _____

Are you currently seeing a psychiatrist? _____ If yes, please give name: _____

Please use this space to include any additional information you would like your therapist to know:

Anne Chester, LCSW, PA
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-7884

Dear New Client:

I am excited about the opportunity to meet with you for therapy. Let me start by telling you a little about myself. I have a Master of Social Work from the George Warren Brown School of Social Work at Washington University in St. Louis. I am licensed as an LCSW or Licensed Clinical Social Worker in the State of Texas. Over the past several years, I have worked in a variety of mental health settings. My goal is to help you overcome life's difficulties through new coping skills and problem solving methods. Below is some general information to help you understand the therapeutic process.

Therapy:

Therapy is the Greek word for change. Seeking professional help is not easy. Honesty is the key to successful therapy. Please know that this is a safe place. The therapist's role is to help you problem solve and not to judge.

Therapy is a process and often a difficult process. Part of the task of being a client is to explore uncomfortable feelings and be honest about behaviors and choices. The therapist with her knowledge of human development and behavior will make observations and suggestions for new ways to approach life's difficulties. It is important for you to explore your feelings and thoughts. It is important for you to try new approaches in order for change to occur. Practice is a vehicle for change.

There are some risks associated with therapy. The main risk is that you may discover things about yourself, child, or significant other that you do not like. Visiting with me in the office will not solve your problems. Treatment requires honesty and work. Growth often occurs when we confront things that induce uncomfortable feelings such as sorrow, grief, or anger. I am not here to judge you but to help you problem solve. As we problem solve, it is your responsibility to follow through with solutions or recommendations made during therapy. The success of your work with your therapist depends on the quality of the effort put forth in the process.

It is not uncommon for things to get worse before they get better. As human beings we are creatures of habit. We often resist change. Changes come with intentional choices and consistency with these choices.

Often, with children especially, poor behaviors will initially escalate as they resist change. Children also want to know if you are going to stay with the changes. After all, if you as the parent do not stay with the changes, then why should the child put forth effort into changing? The main goal for the parent is to stay very consistent.

If at anytime you find that therapy is not working, please call me. You have the right to terminate therapy at any time. However, if you choose to end your session, a termination session is beneficial. Often, people want to quit when things are difficult. Stopping therapy because things are difficult can often make things worse in the long run. Again, please call me if you have questions or concerns.

Therapeutic Relationship:

Our relationship is strictly professional. This means that we will not have a relationship outside of the therapist client relationship. Therapy is about you. Please do not invite me to birthday parties, weddings or other social events. If you see me in a social setting, please know that I will not approach you. If you choose to say hello I will be happy to say hello back. However, I will not discuss treatment issues with you in this type of meeting. This protects you and your privacy as well as provides a safe place for you to talk and problem solve.

Office Hours and Appointments:

I understand that your time is valuable. Office hours are 10:30am to 6:00pm Monday through Thursday. Appointment times are scheduled for you and last 45-50 minutes. If you are late, we may not be able to spend the whole 45-50 minutes. Being on time allows you to get the most out of your session. I will make every effort to be on time and ready for you when you sessions begin. I ask that you extend to me the same courtesy. If you are significantly late, I may ask you to reschedule you appointment.

Appointment Cancellations:

If you need to cancel or reschedule an appointment, please call me in advance. Failure to notify me 24 hours prior to the scheduled appointment time will result in a \$100 cancellation fee. Please record you appointment times as you may not receive a reminder call. Please note that missing 3 sessions without sufficient notice may result in the termination of therapy.

Emergencies/Crisis:

I may not be available after hours or on week-ends for crisis work. During this time, in the event of an emergency, you may call 911 or go to you nearest emergency room.

Payment:

Payment of copays or sessions fees is expected following the session. Any accounts past due 30 days will be forwarded to a collection agency. Please call me if you need to make payment arrangements. If your check is returned due to insufficient funds, you will be charged a \$30 fee in addition to the amount that is due.

Ongoing Communications:

All correspondence will be mailed in an envelope marked "Anne Chester, LCSW, PA." Please immediately advise me of changes to your address or telephone number. By signing this form you are consenting for the therapist to communicate with you by the address, phone number, email address, or fax number that you provide to her. Please note that there are confidentiality risks if you send and email requesting a response or request the therapist contact someone on your behalf. Emails are not encrypted. Phone calls are made via cell phone.

Complaints or Concerns:

Please address any complaints or concerns directly with me as soon as they arise. Your concerns are an important part of your therapy. If you feel that you are unable to resolve issues, with me, please feel free to discuss these concerns with my clinical supervisor. You may also contact the Texas State Board of Social Work Examiners at 800-232-3162 or write to TSBWE; PO Box 141369; Austin, TX 78714-6718.

Informed Consent to Treatment:

By signing this form, I assert that I understand these policies and agree to abide by them. I voluntarily agree to receive mental health services. I voluntarily agree for my child to receive mental health services. I authorize Anne Chester, LCSW to provide such care, treatment, or services to me as are considered necessary and advisable. I understand that I will participate in the planning of my treatment and that I may stop such care, treatment or services at any time. I acknowledge that I have read this packet in its entirety and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I provide consent for Anne Chester, LCSW to evaluate me and commence treatment. I provide consent for Anne Chester, LCSW to provide all clinical information to my insurance company as requested by them for payment/reimbursement of services.

Patient name printed

Date of Birth

Patient signature

Date

Anne Chester, LCSW

Date

**Anne Chester, LCSW, PA
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-7884**

Notice of Privacy Practices

This notice describes how PHI about you may be used and disclosed and how you can get access to this information. Please review it carefully

My Promise to You

I am required by law and regulation to protect the privacy of your personal health information, and to abide by the terms of the notice of privacy practices in effect.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. I will not retaliate against you for filing a complaint with the government or me.

The contact information for the United states Department of Health and Human Services is:
U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described, please feel free to contact me at the address/phone number listed at the end of this notice.

Policies and this notice may change any time. Those revised policies will apply to all the protected health information I maintain. If or when this notice is changed the new notice will be posted or provided to you.

My Responsibilities

I am required by applicable federal and state law to maintain the privacy of your protected health information. Protected health information (PHI) is information about you including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. I am required to give you this notice about my privacy practices, legal duties, and your rights concerning your PHI. I must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until it is replaced.

I reserve the right to change my privacy practice and the terms of this notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my notice effective for all PHI that I maintain, including PHI I created or received before I made the changes. Before significant changes in my privacy practices are made I will make the new notice available upon request.

For more information about privacy practices or for additional copies of this notice please contact me using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

I use and disclose PHI about you for treatment, to obtain payment for treatment and health care operations. Following are examples of the types of uses and disclosures that I am permitted to make.

Treatment

I am permitted to use and disclose your PHI to those involved in your treatment. For example, if you are referred to a specialist, some of your PHI will be shared to facilitate the delivery of care. I may also request that your primary care physician or psychiatrist share information with me about your particular condition.

Payment

I am permitted to use and disclose your PHI to bill and collect payment for the services provided to you. For example, I may complete a claim form to obtain payment from your insurer or HMO. The form will contain PHI, such as a description of the medical service provided to you that your insurer or HMO needs to approve payment to me.

Health Care Operations

I am permitted to use or disclose your PHI for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, I may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure I maintain my compliance with regulations and the law. I also may ask another professional such as a LPC, MD, LCSW to review this practice's charts and medical records to evaluate performance so that I may ensure that the best quality of care is provided to you.

Disclosures That Can Be Made Without Your Authorization

There are situations in which I am permitted by law to disclose or use your PHI without your written authorization or an opportunity to object. In other situations, I will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing to stop future uses and disclosures. However any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse, Neglect, and Health Oversight

I may disclose your PHI for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and deaths), or injury by a public health authority. I may disclose PHI, if authorized by law to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

I may also disclose PHI to a public agency authorized to receive reports of child abuse or neglect. Texas law requires mental health professionals to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or disabled.

I may disclose your PHI to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

I may disclose your PHI in the course of judicial or administrative proceedings in response to an order of the court or the administrative decision maker or other appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by a law enforcement official, I may disclose your PHI under limited circumstances provided that the information: is released pursuant to legal process, such as a warrant or a subpoena; pertains to a victim of crime and you are incapacitated; pertains to a person who has died under circumstances that may be related to criminal conduct; is about a victim or a crime and I am unable to obtain the person's agreement; is released because of a crime that has occurred on these or other business premises; or is released to locate a fugitive, missing person or suspect. I may also release the information if I believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

I may disclose your PHI as required by the Texas Workers' Compensation Law.

Inmates

If you are an inmate or under the custody of law enforcement, I may release your PHI to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care to protect your health or the health and safety of others or the safety and security of the institution.

Military, National Security and Intelligence Activities Protection of the President

I may disclose your PHI for specialized governmental functions such as separation or discharge from military services, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an institutional review board or privacy board, I may release PHI to researchers for research purposes. I may release PHI to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also I may release your PHI to a coroner or medical examiner to identify a deceased or a cause of death. Further I may release your PHI to a funeral director where such a disclosure is necessary for the director to carry out his disclosure.

Required by Law

I may release your PHI where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. I will not retaliate against a patient that exercises their HIPAA rights.

Requested Restriction

You may request that I restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. I do NOT have to agree to this restriction, but if I do agree, I will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing:

1. the information to be restricted
2. what kind of restriction you are requesting (i.e. in the use of information, disclosure of information or both)
3. to whom the limits apply.

Please send the request to the address listed at the end of this notice.

You may also request that I limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative

Means you may request that I send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to me at the address listed below. I am required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want me to communicate with you and if you are directing me to send it to a particular place, the contact/address information.

Inspections and Copies of Protected Health Information

You may inspect and or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that request for copies are made in writing and I ask that requests for inspection of your health information also be made in writing. Please send your request to me at the address listed at the end of this notice.

I can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

1. includes psychotherapy notes
2. Includes the identity of a person who provided information if it was obtained under a promise of confidentiality
3. Is subject to the Clinical Laboratory Improvements Amendments of 1988
4. Has been compiled in anticipation of litigation.

I can refuse to provide access to or copies of some information for other reasons, provided that I provide a review of my decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that I provide copies or a narrative within 15 days of your request. I will inform you of when the records are ready or if I believe access should be limited. If I deny access, I will inform you in writing.

HIPAA permits me to charge a reasonable cost based fee. Fees will be assessed and charged on the bases of limits set by HIPAA and or Texas State Board of Social Work Examiners.

Amendment of PHI

You may request an amendment of your PHI in the designated record set. Any such request must be made in writing to the person listed at the end of this notice. I will respond within 60 days of your request. I may refuse to allow an amendment if the information:

1. Was not created by myself or other professionals that may be part of this practice
2. is not part of the designated record set
3. is not available for inspection because of an appropriate denial
4. if the information is accurate and complete.

Even if I refuse to allow an amendment you are permitted to include a client statement about the information at issue in your medical record. If I refuse to allow an amendment I will inform you in writing. If I approve the amendment, I will inform you in writing, allow the amendment to be made and tell others that I now have the correct information.

Accounting of Certain Disclosures

The HIPPA privacy regulations permit you to request and for me to provide an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures within a 12 month period will be free. For additional requests within that period, I am permitted to charge for the cost of providing the list. If there is a charge I will notify you and you may choose to with draw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives and Other Health-Related Benefits

I may contact you by telephone, mail or both to provide you with appointment reminders, information about treatment alternatives, or other health-related benefits and services that maybe of interest to you.

Contact Information for Requests

Anne Chester, LCSW
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-2884

Anne Chester, LCSW, PA
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-7884

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this practice's Notice of Privacy Practices, which explains how my PHI will be used and disclosed. I understand that I was presented and/ or received a copy of this document.

Client name

Date of Birth

Signature of Client

Date

Anne Chester, LCSW

Date

Anne Chester, LCSW, PA
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-7884

Client Confidentiality Information and Consent

All information between counselor and client is held strictly confidential unless:

1. The client authorizes a release of information with his or her signature
2. The client presents a physical danger to self
3. The client presents a physical danger to others
4. Child/elder abuse or neglect is suspected
5. The client seeks treatment to avoid detention or apprehension or enable to commit a crime
6. You are under the age of 16 and are a victim of a crime
7. To decide an issue concerning a deed or conveyance, will or other writing executed by you
8. You file a suit against your therapist for breach of duty or your therapist files suit against you
9. You are involved in criminal prosecution
10. You have filed suit against anyone and have claimed mental or emotional damages as part of the suit
11. You file a complaint with the licensing board
12. There are fee disputes between the therapist and the client (collections)
13. The court orders release or review of the records
14. Situations which, in the therapist's judgment, it is necessary to warn or disclose for safety
15. You have consented to disclosure by signing a release of information form
16. If you are under the age of 18, your parent and/or legal guardian is entitled to all information about your treatment such as your goals, your progress, the focus of sessions, and treatment recommendations etc. If you do not want specific details disclosed to your parent, your parent must sign a confidentiality waiver form
17. AIDS/HIV infection and possible transmission
18. If a claim is filed with you insurance company for payment or reimbursement of services. In this case, the insurance company has the right to review all records including diagnosis.

In the case of abuse or suspected abuse I am required by law to notify appropriate authorities.

If you have any further questions, please discuss them with me. By signing this form, you are giving your consent to the undersigned therapist to share confidential information to any persons mandated by the law and the managed care company responsible for providing and paying for mental health services. You are releasing to hold harmless the undersigned therapist from any departure from your right to confidentiality that may result.

Patient name printed	Date of Birth	Social Security #
Patient signature	Date	
Parent or Guardian Signature	Date	
Anne Chester, LCSW	Date	

**Anne Chester, LCSW, PA
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-7884**

Treatment and Financial Contract

I, _____ consent for Anne Chester, LCSW to bill my insurance company for services rendered. If my insurance company denies my claim, I understand that I will be billed at the rate of \$100.00 per hour for services rendered.

I understand that Anne Chester, LCSW may not be on my insurance panel. If insurance assignment is not accepted, I understand that payment of \$100.00 per hour is due at the time that services are rendered.

I understand that a scheduled appointment means that time is reserved for me. If an appointment is missed or cancelled with less than 24 hours notice, I will be billed according to the scheduled fee.

I understand that 3 missed appointments without sufficient cancellation notice may result in the termination of treatment.

If I am asked to have the client assessed by a psychiatrist, I will comply.

I understand that this is a legally binding contract and that any changes, additions, or subtractions will be agreed upon by both parties in writing.

Signature of client

Date

Anne Chester, LCSW

Date

**Anne Chester, LCSW, PA
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-7884**

Policies Regarding Court, Depositions, Subpoenas, and Any Other Legal Matter

Anne Chester, LCSW is not trained for any type of court work. Anne Chester, LCSW is not trained to advise on legal matters. Anne Chester, LCSW cannot evaluate cases for custody. Anne Chester, LCSW is not trained to be an expert witness in any matter.

I understand that if I am involved in any legal action that requires testimony or deposition, that Anne Chester, LCSW will charge a fee of \$300.00 per hour portal to portal. This fee also includes time spent preparing for the testimony or deposition and making copies of any records involved. I understand that I am responsible for this fee even if it is the opposing attorney requesting records, deposition, testimony, or other services. A \$1,500.00 deposit is due within two (2) business days of my receiving notice from Anne Chester, LCSW that she has received the subpoena, notice of deposition, or other request concerning judicial activity. Should the subpoena require Anne Chester, LCSW to be present for court, deposition, or other judicial activity in less than 48 hours, the \$1,500.00 deposit is due immediately upon my receiving notice from Anne Chester, LCSW that she has received such subpoena or other notice and an additional fee of \$500.00 will be charged in addition to the regular hourly fee of \$300.00, due to the need of Anne Chester to alter her patient schedule on such short notice.

Requests for records in any legal matter pertaining to a minor will require either the signature of a custodial parent or a court order from the judge for Anne Chester, LCSW to release any records. Requests for records in any legal matter pertaining to an adult will require either the signature of the adult client or a court order from the judge for Anne Chester, LCSW to release any records.

Signature of client

Date

Anne Chester, LCSW

Date

Anne Chester, LCSW, PA
P.O. Box 471081
Ft. Worth, TX 76147-1081
817-939-7884

Medical Release of Information

Client's Name: _____ D.O.B. _____ Social Security Number: _____

By signing this form, I authorize you to release and or receive confidential health information, by releasing or receiving a copy of my medical information, or a summary or narrative of my protected health information, to PCP, Psychiatrist, or Entity listed below.

Please Check:

_____ Release my protected health information to the following person(s)/entity

_____ Receive my protected health information to the following person(s)/entity

Name of PCP, Psychiatrist or entity to release or receive information to/from:

Name: _____

Street: _____

City _____ State: _____ Zip: _____

Telephone: _____

The reasons or purposes for information needed is: _____

Limitations on the information you may release subject to this release form are as follows:

If none, mark through and initial:

I understand that unless I request to revoke this authorization this request will remain in effect as long as the above client remains in treatment.

Signature of client, parent, guardian or legal representative

Date

Anne Chester, LCSW

Date