Consent for Release of Information (ROI) and Use of Confidential Information

________________________ _____ _________________________ ___________________
Client First Name M.I Client Last Name Date of Birth

I hereby give my consent for *BTConcepts Staff* to:

___receive information ___give information ___exchange information

With (Information Regarding Authorized Party):

_______________________________________ _______________________________
Printed Name (First, Last) Relationship to Client

____
Contact Information (Phone Number[s])

	Intake Information			Social History
	Progress Notes			School/Work Records
	Treatment Plan			Attendance Records
	Medical History			Service Coordination
	Developmental History			Discharge plan

____Other: ____
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I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to my therapist. I also understand that I will not be able to revoke this consent in cases where my therapist has already relied on it to use or disclose my mental health information. Written renovation of consent must be sent to BTConcepts office.

*This ROI will expire on _______________

I understand that I have the right to request that my therapist restrict how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that my therapist does not have to agree to such restrictions, but that once such restrictions are agreed to, my therapist must adhere to such restrictions.

______________________________________ _________________________
Printed Name & Signature) Date

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Relationship to Client