

# Sacha M Sanger – LMHC

## Consent to Release Confidential information to Coordinate Care

Phone: (518) 223 - 9439

Fax: (518) 203-1314

Email: [sacha@sachasangerlmhc.com](mailto:sacha@sachasangerlmhc.com)

Date: \_\_\_\_\_

### CLIENT INFORMATION

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Client Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### REFERRING PROVIDER

Referring Provider Name/Agency/Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

### PROVIDER INFORMATION

Provider/Agency/Individual Name: Sacha M Sanger - LMHC

Address: 22 US Oval Suite 204

City: Plattsburgh State: NY Zip: 12903

Phone: (518) 223 - 9439

Fax: (518) 203-1314

The undersigned authorizes the release of the following protected health information. The purpose of such release is to allow for coordination of care, which enhances quality and reduces the risk of duplication services. PLEASE CHECK

ANY/ALL patient records related to treatment and case consultation requested

Consent for mutual disclosure of information TO and FROM Referring Provider and Sacha M Sanger - LMHC

OR Limited to (select all that apply)

Dates of Treatment

Treatment Summary/Discharge Report

Diagnosis

Assessment/Evaluation Report

Case Consultation

Progress Notes

Treatment Plan

Consent for mutual disclosure of information between Recipient and Provider

- I understand this authorization may be modified or revoked at anytime. Any modification or revocation of this authorization must be in writing to participating Provider and Recipient.
- I understand I am entitled to a copy of this authorization.

X \_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records may be protected under the Federal Confidentiality Regulations (42CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken upon it, by giving written notice to the parties above.