

STRATARA GROUP, LLC
RELEASE OF INFORMATION

I hereby authorize Stratara Group, LLC/Elisabeth T. Schneider, LMFT to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my mental health care and the payment of my mental health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 180 days from the date of signature or at the date or event specified here _____ (Expiration date/event)

I further understand that I may revoke this authorization at any time by notifying, in writing, Stratara Group, LLC /Elisabeth T. Schneider, LMFT. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

Patient Name _____ Date of Birth _____

Address: _____

Please release the following information for these treatment dates:

_____ (d/m/y) To _____ (d/m/y)

The information will be released to:

Individual/Organization Name Street Address: _____

Purpose of the use and/or disclosure:

Continued Care ___ Legal ___ Insurance ___ Personal Use ___ Other ___

Record copy delivery: Pick-up ___ Mail ___ Fax ___ Phone ___ Email ___**Information to be released:**

Summary Abstract (intake paperwork, dates of service, diagnosis): ___

Progress Notes: ___

Complete Chart: ___

Other: _____

I understand the record might not be complete, if there has been a recent visit, and additional documentation could be added after submitting this request.

Signature of Patient or Legal Representative (electronic signatures not acceptable)

Printed Name of Patient or Legal Representative

Representative's Authority to Act for Patient (attach supporting documentation)

Date
