Heather Roselaren, LCSW/MPH LCS #14038

Consent to Release Information to Other Providers

I hereby authorize Heather Roselaren, LCSW/MPH to exchange medical records and information pertaining to medical history, mental or physical condition, services rendered or treatment with:

(you doctor's name): _____.

[X] and any other people at their office involved in my care (normally checked – cross out if not wanted).

concerning:

(name of the client--usually you): _____

This requester may use the medical records and information authorized only for the following purposes (normally both are checked -- cross out if not wanted):

[X] Further Treatment
[X] Coordination of Care

This authorization shall become effective immediate;y and shall remain in effect for (choose one:)

[_] duration of treatment [_] 1 year [_] until this date: _____.

Signature(s) of Client(s): _____

(if signing on behalf of client, relationship to client: _____)

Date Signed: _____

Date Printed: _____

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