Elena Dasgupta-Tsinikas, LCSW

CONSENT FOR RELEASE OR EXCHANGE OF CONFIDENTIAL INFORMATION

Name of Client _____ **Date of Birth** _____

I hereby authorize the **release and exchange of information** between my therapist:

Elena Dasgupta-Tsinikas, LCSW
3840 Woodruff Avenue, Suite 108, Long Beach, CA 90808

And the following individual, agency, or institution:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

The following information to be disclosed is for the sole purpose of continuity of care:

___Admission/Discharge Summaries
___Educational Assessment/Records
___Medical History/Physical Exam
___Psychiatric Evaluation/History
___Vocational Assessment/History
___Consultations
___Treatment Plans
___Psychological Eval/Assessment
___Social History/Assessment
___All appropriate records

Other:_____

This consent will expire 90 days after Termination/Discharge. I understand that I may revoke this consent at any time, except to the extent that action has already been taken, by informing all of the above parties in writing. I also have the right to retain a copy of this release.

The parties named above are hereby released from all legal liability that may arise from this exchange or release of information. A photocopy or electronic copy is as valid as the original. This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Signature:_____ Date _____
(Client)

Signature:_____ Date _____
(Parent or Authorized Representative)