Authorization Consenting to Release of Patient Information

By my signature below, I authorize Lisa Fladager, MCAT, LMHC, R-DMT, CMA to receive, provide, and exchange information (verbally and in writing) about me obtained during the context of my evaluation or psychotherapy, with the following person(s) or staff of the named clinic, agency, or institution:

_____

(Name of Agency and / or Person)

_____

(Street or PO Box)

_____

(City, State, Zip)

_____

(Phone, fax, e-mail)

Purpose of Exchange / Release of Information

This exchange of information is for the following purpose(s):

(i) _____ Consultation (ii) _____ Evaluation (iii) _____Other

If "Other" reason, please specify _____

_____

_____

I understand that I may revoke this consent at any time. The revocation must be made in writing.

This consent will be in effect for five years from the date of the last psychotherapy session, unless revoked in writing earlier, or renewed.

_____

(Please print your name) (Date) (Signature)

Lisa Fladager, MCAT, LMHC, R-DMT, CMA
PO Box 861, Langley, WA 98260
(360) 221-2677 temenos@lisafladager.com