Consent to Coordinate Treatment

Client's Name: _____Birth Date: _____/_____/_____

I, _____, hereby authorize Planted Healing practitioners and providers to release/discuss relative information to, and receive information from the providers listed below for the purpose of coordinating treatment and/or consultation.

I give permission for the following information to be released or received:

___ Assessments and Diagnosis

___Psychological/Psychiatric Assessments

___Treatment Summaries /Recommendations

___Medical Records/labs

___ Other _____

This authorization for release of protected information is specifically limited to the information specified above and is made according to the Health Insurance Portability and Accountability Act (HIPPA). State and federal laws prevent disclosure of your protected health information without your consent. This release shall remain in effect until 90 days after discharge from treatment, unless otherwise modified.

_____ _____

Client's Signature (Parent/Guardian if under 18 years old) Date

_____ _____

Witness/Provider Signature Date