Bishop's Counseling
FOR WOMEN

Jennifer Bishop, LCSW
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CONSENT TO RELEASE INFORMATION

This document authorizes Jennifer Bishop, LCSW to exchange confidential information concerning _____ with the following person(s):

(Client Name/ Names)

Please check all that apply:

_____**Insurance Company/ EAP/ Managed Care** _____Other: _____

_____**Relative** Name:_____ Relationship:_____

Home #:_____Cell #:_____Email:_____

_____ **Psychiatrist:** _____ Number: _____

_____ **Primary Care Physician:** _____Number: _____

_____ **Therapist:** _____ Number: _____

Refused contact with: _____**Primary Care Physician** _____**Psychiatrist**

The purpose of this disclosure is as follows:

_____ **Authorization/ Utilization Review** _____ **Payment/ Billing**

_____ **Coordination of Care** _____ **Other** _____

I acknowledge that Jennifer Bishop, LCSW may return calls by cellular phone.

I understand that I may revoke, in writing, my consent to allow the above named counselor to release this information at any time, except to the extent that action will have been taken on information released prior to the revocation of my consent. Otherwise, this consent is valid until counseling ends.

Client Signature/Date_____Date:_____

2nd Client Signature/Date_____ Date:_____

Parent/Guardian (if client is a minor)_____Date:_____

Witness/Therapist _____ Date:_____