Mark R. Cunningham M.S., MFTC
Adaptive Therapy LLC

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Consent for the Release of Confidential Information

I, _____ on behalf of _____
(Name) (Self or child's name)

hereby authorize **Mark R. Cunningham, M.S.**, to release information to and receive information from:

_____
(Name of person(s) or organization(s) to which disclosure is to be made)

Information to be disclosed:

- ☐ Treatment Plan ☐ Diagnosis ☐ Medical/Hospital Records
- ☐ Course of Treatment ☐ Evaluation ☐ Psychological/Medical Test Results
- ☐ Mental Health Treatment Records ☐ Other _____

The purpose of such disclosure:

- ☐ Ongoing Treatment ☐ Consultation Transfer ☐ Medical Care
- ☐ Coordination of Care ☐ Evaluation Billing ☐ Legal Issues
- ☐ Other _____

Mark Cunningham and the above stated person(s) or organization(s) may:

- ☐ discuss in person or by telephone the content of the information authorized for release.
- ☐ transmit any authorized information via fax.
- ☐ transmit any authorized information via electronic communications (e-mail, internet).

Exceptions or Exclusions to this Release: _____

This release will automatically expire upon the completion of treatment unless otherwise specified. The date, event, or condition upon which this consent expires is: _____.

Authorization: I certify that the information given above is accurate to the best of my knowledge. A copy or fax of this release shall be as valid as the original. I understand that I may revoke this authorization at any time in writing and the revocation will not be effective until a written notice is provided. If I have authorized disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. If I have any questions about disclosure of my health information, I may contact Mark Cunningham for further information. I acknowledge that the information to be released was fully explained to me and this consent is given voluntarily. Furthermore, I certify that I have the legal authority to authorize this release. I hereby release all parties stated herewith from any liability resulting from the release of this information.

_____ _____
Client Name (please print) **Client Signature (if necessary)** Date

_____ _____
Parent/Guardian Signature Date **Parent/Guardian Signature** Date

_____
Therapist Signature Date