



INFORMED CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Name:	Date of Birth:
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OFFICE COPY

I, _____
(Client's Full Legal Name, Date of Birth and last 4 SSN)

do hereby consent and authorize Magna's Haven, Inc. as to obtain from:

(Name of Person/Title/Organization)

(Address/City/State/Zip Code/Phone Number/Fax Number)

The following information pertaining to myself:

THE INFORMATION WHICH MAY BE DISCLOSED IS (Check/ Circle All That May Be Released):

- Presence in Treatment (admit/discharge date)
- Diagnosis, Brief Description of Progress/Prognosis
- Multidisciplinary Discharge Summary/Continuing Care Plan
- Information Necessary for the Processing and Payment for Billing
- Bio-psychosocial/Diagnostic Summary
- Medication History
- Nursing Assessment
- Admission Psychiatric Assessment
- Admissions Profile
- Physician Attestation Statement

THE INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSES (Check/ Circle All That Apply):

- To Provide Ongoing Treatment/Continuing Care
- To Coordinate Treatment Efforts with My Family/Significant Other/Concerned Person
- To Coordinate Treatment and Continuing Care Efforts with my Employer/ Employee Assistance Program
- To Enable Judges, Attorneys, Probation/Parole Officers, to Support My Treatment Goals or to
- Make Legal Decisions on my behalf

Jessica Kuilan, LCSW d.b.a.
Magna's Haven, Inc.
Jacksonville, FL 32256
Miami, FL 33157
(305) 783-3991



INFORMATION AND CONSENT FOR ASSESSMENT AND TREATMENT

Name _____

Date of Birth _____

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- To Allow Insurers to Resolve Payment of Claims for Billed Services
- All of the Above
- Other:

THE DURATION OF THIS AUTHORIZATION IS UNTIL: (Check / Circle all that Apply):

- Six months from the date of discharge from treatment
- Resolution of billing for facility services
- Twelve months from the signature on this form (to be renewed annually)
- Other:

I understand that I may **revoke** this consent **at any time** by notifying the therapist in writing. A copy of this authorization is to be considered as valid as the original document.

Signature of Client and Date:	Signature of Parent/Legal Guardian and Date (when applicable):

NOTICE TO RECIPIENT OF INFORMATION: The Recipient of this consent is hereby required by law to abide by the federal regulations set forth within the four corners of this consent to protect the confidentiality of the individual to whom it pertains to.

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