PROGRESSWELLNESS LLC
WITH ANGELA FICKEN, LICSW

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RELEASE/EXCHANGE OF HEALTH CARE INFORMATION (OPTIONAL)

I, _____, whose date of birth is _____/_____/_____, hereby authorize the health care provider Angela Ficken, LICSW to release, receive, and/or share medical records or any pertinent information related to the development, implementation, and evaluation of my individual treatment plan, and to the payment of claims for services to Angela Ficken, LICSW.

Provider Type: _____

Provider Name/Credentials: _____

Contact (Telephone/Email): _____

Primary Care Physician (i.e. MD, DO, NP): _____

Case Manager (include facility name): _____

Other: (Family, Friend, Significant other): _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Angela Ficken, LICSW. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

By signing below, I acknowledge that I have read, understand, and agree to the above policy.

Printed Name: _____

Signature: _____

Today's Date: _____/_____/_____

Parent/legal guardian signature is required for any patient under 18 years of age.

Printed Name: _____

Signature: _____

Today's Date: _____/_____/_____