Lisa Binz Mongoven, Psy.D.
Clinical Psychologist

Consent to Release Information

This document authorizes Lisa Binz Mongoven, Psy.D. to release confidential information concerning:

_____ _____to the following person(s):
(Patient) (Date of Birth)

☐ Relative Name: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

☐ Psychiatrist: _____ Number: _____

☐ Primary Care Provider: _____ Number: _____

☐ Therapist: _____ Number: _____

☐ Insurance Company / Managed Care / EAP

☐ Other: _____

The purpose of this disclosure is to allow for:

☐ Coordination of Care ☐ Payment / Billing

☐ Authorization / Utilization Review ☐ Other_____

I acknowledge that Lisa Binz Mongoven, Psy. D. may return calls by cellular phone.

I understand that I may revoke this release at any time. Otherwise, this consent expires one year from the date noted below.

Client Signature_____ Date _____

Parent / Guardian_____ Date _____

Witness / Therapist _____ Date _____