ELEVATE
COUNSELING SERVICES, INC.

117 EASTMAN ST #102, SO EASTON, MA 02375
116 MECHANIC ST, #7, BELLINGHAM, MA 02019
695 WAREHAM ST, SO MIDDLEBORO, MA 02346
PH: 508-202-1811 FAX: 508-297-1647

Date:_____

Dear: _____ :
Name and address of Health Care Practitioner

To coordinate care, I wish to inform you that your patient, _____
was seen for an initial evaluation on _____. This is a new release ____/updated release ____ of information.
He/She meets the DSM-5 criteria for _____ .
Outpatient care is being delivered and a treatment plan consists of the following modalities:

____Individual Counseling ____Couples Counseling _____ Family _____ Group

If you need additional information, or if you have any concerns, I can be reached at 508.202-1811. My secured fax number is 866.773.4171.

Sincerely,

Clinical Therapist

Name: _____DOB:_____

I authorize Elevate Counseling Services, Inc. to release/exchange information with my Primary Care Physician and/or Psychiatric Prescriber. *The following information will not be released unless you specifically authorize it by checking the relevant spaces provided.*

1 I specifically authorize the release of information pertaining to drug and alcohol use, diagnosis and treatment ____
2 I specifically authorize the release of information pertaining to HIV/AIDS test results. ____

Notice

Elevate Counseling Services, Inc., and any other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your rights: **This authorization to release health information is voluntary**. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) To conduct research related to treatment. (2) To obtain information in connection with eligibility or enrollment in a health plan. (3) To determine an entity's obligation to pay a claim. (4) To create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Elevate Counseling Services, Inc. You are entitled to receive a copy of this authorization. This authorization to release information expires 12 months from the date of signature.

Print name:_____Signature:_____Date:_____