School Treatment Notification: Patrick McKee, LCPC

To: _____
(Phone/fax/address for school)

From: Patrick McKee, LCPC

Attached is a release letter from one of your students.
This letter includes a release of information, giving Patrick McKee, LCPC**,** and yourself, permission, to discuss this student. It also includes a brief summary of our assessment and treatment plan.
Please contact me if you have additional information that would be relevant to our treatment of this student, or if you have any questions about the treatment plan.
Sincerely,

_____
Patrick McKee, LCPC
847-922-5278
www.patrickmckeelcpc.com
email: patrickmckeelcpc@gmail.com

401 E. Prospect Ave, Suite 208 Mount Prospect, IL 60056
Phone: 847-922-5278 Email:patrickmckeelcpc@gmail.com
www.patrickmckeelcpc.com

Treatment Notification/Release, p. 2.
Dear: _____
(Phone/fax/address for school):
Your student, _____, is currently in treatment Patrick McKee, LCPC**,** and has signed this release allowing us to exchange information.

Authorization to release and request information:
I hereby consent to have Patrick McKee, LCPC release _____ (initial) and/or obtain _____ (initial) information regarding _____, SS # _____ DOB, _____,
To/from my school, _____.
I consent to disclosure of/request for the following specific information:
_____ Entire Treatment Plan ____ Educational/Academic Records
_____ Psychological Testing Report ____ All Special Education Records
_____ Treatment Plan and Progress ____ All School Records
_____ Other (specify) _____
This disclosure is for the purpose of coordination of care. I understand that this consent can be revoked at any time by submitting a written and dated notice of revocation. I understand that Patrick Mckee, LCPC cannot be held liable for any disclosures authorized by this release, that occurred prior to the date of revocation.
I understand that unless revoked by written notice, this authorization of information is valid and binding for one year from the date signed.
Signature of client: _____ Date: _____
Signature of Parent/Guardian: _____ Date: _____
Signature of others (those 12 or over who attended sessions):
_____.
Witnessed by: _____ Date: _____

Treatment Notification, p. 3.
Student: _____: Date of birth: _____

Clinical Information:

Reason for referral/Presenting problems:
Diagnosis:
Treatment plan:
Current psychotropic medication (list):
Special Concerns (if any):
Please contact me if you would like additional information or have any information you believe I should be aware of.

Patrick McKee, LCPC
Signature: _____ Date: _____
Phone: 847-922-5278

TREATMENT UPDATE

Progress to date:

New concerns/issues/changes in diagnosis:

Patrick McKee, LCPC
Signature: _____ Date: _____

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