**THIS IS ONLY A SAMPLE**
**PLEASE WRITE YOUR OWN BASED ON THE SPECIFIC NEEDS/SITUATIONS OF YOUR PRACTICE**

## PERMISSION FOR EXCHANGE OF INFORMATION

I, _____, hereby authorize _____
Practitioner/Provider
to **RELEASE / RECEIVE** information contained in the record

of _____DOB _____**TO /FROM**

PERSON/ORGANIZATION/PROVIDER_____

ADDRESS_____

_____

THE FOLLOWING INFORMATION MAY BE **RELEASED/RECEIVED**:

___Intake/Assessment
___Psychiatric Eval.
___Psychological Eval.
___Progress Notes
___Treatment Plan
___Discharge Summary
___Vocational Skills Assessment
___Medical Reports
___Neurological Reports
___Physical Exam
___Immunizations
___ Laboratory Testing
___Individual Education Plan
___Teacher Observations
___Achievement Tests

Other: _____

For the purpose of: _____

Effective Date(s) From: _____ To: _____

I fully understand the nature of this consent and that this authorization shall remain in effect from the date of my signature for a period not exceeding 1 year. However, I may revoke this authorization at any time by written, dated communication. A photocopy of this authorization will be considered valid, and all information will be held in strict confidence. I understand that the policy of _____ is to release only that information about a present or former
Practitioner/Provider
recipient of services which, in the judgment of its personnel, is considered essential to the purpose for which the authorization is requested. It is also the policy of _____, **to release only information**
Practitioner/Provider
**generated by them and not to other practitioners/providers.**

_____ _____
Member Signature (14 yrs.and older) Date

_____ _____
Parent(s)/Legal Guardian(s) and Relationship to Child Date

_____ _____
Witness (Signature and Title) Date

**To be completed if the recipient of services is physically unable to provide a signature, but has indicated, verbally or behaviorally, that he/she consents to the release.**

We affirm that_____was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain effective from this date to _____(1 years hence). However, this may be revoked by verbal or behavioral communication to the treating provider.

_____ _____
Witness (Signature and Relationship) Date