AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO OTHER HEALTH PROVIDERS

Communication between your health providers is important to ensure that you receive comprehensive and quality health care. This information will not be released without your signed authorization. Signing below allows us to share your protected health information, such as diagnosis, treatment plan, progress notes etc, with the health care provider listed on this authorization, and vice versa.

I, _____ authorize Child and Family Consultants Inc. to release
(Client/ Child's Name)
or request protected health information related to my evaluation and treatment to/from:

_____
Primary Care Physician

_____
Provider Address

_____
Provider City, State and Zip

_____
Provider Phone

PATIENT RIGHTS

You may cancel this authorization to use or disclose information at anytime. If you end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices. You cannot be required to sign this form as a condition of treatment, payment or eligibility of benefits. You do not have to agree to this request to use or disclose information. You have a right to a copy of this signed authorization. This consent expires upon discharge.

_____ _____
Authorized Signature Date

Relationship to Client _____