Little Johnny, LLC

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Lexington, SC 29072

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**CONSENT TO RELEASE & EXCHANGE CLIENT INFORMATION**

I want the following information shared for treatment, evaluation planning, and/or service coordination. By signing this form, I am allowing service providers or agencies to exchange information that will be useful in planning current treatment and/or evaluations, and/will make it easier for them to work together effectively in planning and/or providing services.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information should only be exchanged with:

Name(s)/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expiration & Terms:** I understand that this consent is good until one year from the date of my signature below, and that it encompasses consent to release information from before the signature date as well as additional information received after this consent is signed. In addition, I understand that information may be shared in writing, via email, in computerized form, and/or in meetings or by telephone.

**Revocation:** I understand that I can withdraw this consent at any time. The revocation will not apply to information that has already been released. I must revoke this Consent in writing to Little Johnny, LLC. This will stop the listed parties from sharing information after they know my consent has been withdrawn. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I authorize Little Johnny, LLC to exchange:

\_\_\_ Psychological/Diagnostic Evaluation \_\_\_ Educational Assessment

\_\_\_ School Records \_\_\_ Progress Update

\_\_\_ Medical History \_\_\_ Developmental History

By signing below, you acknowledge you have read this form and agree to abide the terms. If you have any questions or need clarification, please contact us immediately.

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Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name