Deborah Calvanese, LMHC 5 Noble Ave., 1st Floor, Westfield, MA 01085 Phone: 413-297-2719 Fax: 413-562-1658

**CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION**

Clients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize, Deborah Calvanese, LMHC, to release to \_\_\_\_\_ and/or exchange information \_\_\_\_\_ with the following party:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Relationship: PCP\_\_ Self\_\_ Spouse/Significant other Parent\_\_ Child\_\_ Sibling\_\_\_ Other\_\_\_\_\_\_\_\_\_

**The purpose of this release is for:**

\_\_\_\_\_ Continuity of care \_\_\_\_\_ Coordination of care with another treating healthcare provider \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information released will be limited to:**

\_\_\_\_\_ Attendance \_\_\_\_\_ Summary of pertinent psychiatric and psychosocial history \_\_\_\_\_ Treatment summary \_\_\_\_\_ Complete mental health assessment and treatment records \_\_\_\_\_ Any information deemed necessary to coordinate care \_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand any record may contain information about drug or alcohol use.** I am \_\_ I am not\_\_ willing to share this information with the party named above.

**I understand any record may contain information relating to my AIDS or HIV status.** I am \_\_ I am not\_\_ willing to share this information with the party named above.

The client understands that s/he has a right to a copy of this form. This consent is subject to revocation at any time in writing, except to the extent that action has been already taken in reliance thereon. If not revoked earlier, this consent expires one year from the date signed.

The client understands the party named above may not be covered by State or Federal Laws, and they may be allowed to further share the information that has been given to them.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Client or Guardian Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print name Relationship to client