Reciprocal Consent for Release of Confidential Information for Treatment

SANTOSHA
WELLNESS

I, _____, date of birth _____, hereby authorize the following people/organizations to release information in my client/child's records to one another in order to best coordinate care. I acknowledge that I am the legal guardian/parent of my child, _____, date of birth _____.

Information may be released only under the conditions listed below. Name of person(s) or organization(s) between whom disclosure is to be made:

Name: _____

Organization: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Name: _____

Organization: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Name: _____

Organization: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Name: _____

Organization: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Specific type of information to be released: _____

Purpose of disclosure: _____

Limitations or information not to be shared: _____

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I understand what information is to be released and the intended use of that information. I am aware that this consent can be revoked in writing at any time. My signature also indicates that I have read this form and/or have had it read to me and explained in language that I understand. All blank spaces have been filled in except for signature and dates. I also understand that treatment cannot be denied or withheld for refusing to authorize a release of information.

This consent form expires at the termination of treatment, unless otherwise specified or at the verbal or written revocation of this consent for release of confidential information.

Signature: _____ Date: _____