AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

PLEASE PRINT

PATIENT NAME: _____ DATE OF BIRTH: _____

I authorize Dr. Neil Fullan and Anima Family Counseling to exchange information with the following party or parties. ***Please include phone, fax, and address.***

_____

(Name of person or organization, phone, fax, and address)

_____

(Name of person or organization, phone, fax, and address)

_____

(Name of person or organization, phone, fax, and address)

Purpose of Exchange of Information

By signing this release, I give my consent to the above provider to exchange information, either verbal or written, via mail or electronic media to the party or parties listed above. I understand that this may include the release of information pertaining to psychiatric evaluations, progress and session notes, consultations, and any other information related to my ongoing treatment. I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal standards and my health information may be re-disclosed without my authorization.

I understand that I have the right to inspect and receive a copy of the disclosed material and a copy of this consent form as established in this agency's policies and procedures. This authorization to release information may be revoked by me at any time, in writing, except to the extent that action has been taken in reliance therein. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be reproduced by federal privacy standards.

This authorization will remain in effect until revoked _____.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian Date