Consent For Release Of Protected Health Care Information

I, _____, hereby authorize Diane Forse, LCSW to exchange, release or obtain private health care information pertinent to my treatment with:

Name:
_____

Type of Professional: _____

Agency:
_____

Address:
_____

Phone(s):
_____

This information is requested for the purpose of:
_____Consultation
_____Coordination of Care
_____Other:
_____

I release Diane Forse, LCSW from any legal liability resulting from the release of this information with the understanding that she will exercise reasonable professional standards.

I understand that once protected health information is disclosed, it may be disclosed by the recipient and may not be protected by federal privacy laws or regulations. In addition, I understand that as a part of the treatment of the identified patient, family history information may be released.

I understand that this consent may be revoked by the patient at any time except to the extent that the disclosure has already been made in reliance on the previously given authorization. To revoke this authorization, send written notification to this office.

This consent expires 12 months from the latter date of: when treatment ends or when the form was signed.

This form has been fully explained and I certify that I understand it's contents.

Client's Signature _____ Date _____

Parent/Guardian Signature (if required) _____ Date_____

Print name: _____