



**CONSENT TO RELEASE & EXCHANGE INFORMATION FOR CLINICAL SERVICES**

*I want the following information shared for treatment 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 will make it easier for them to work together effectively in planning and/or providing services.*

\_\_\_\_\_  
(Please Print Full Name of Client Legibly)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Client's Date of Birth)

\_\_\_\_\_  
(Client's Social Security Number)

My relationship to the client is:       Self       Parent       Guardian

I want the following confidential information about the client to be exchanged:

- |   |   |
|---|---|
| <input type="checkbox"/> Psychological/Psychiatric Assessment Information | <input type="checkbox"/> Medical Assessment Information |
| <input type="checkbox"/> Psychological/Psychiatric Treatment Records      | <input type="checkbox"/> Medical Treatment Records      |
| <input type="checkbox"/> Synopsis of Psychological/Psychiatric Treatment  | <input type="checkbox"/> Synopsis of Medical Treatment  |
| <input type="checkbox"/> Psychological/Psychiatric Diagnosis              | <input type="checkbox"/> Medical Diagnosis              |
| <input type="checkbox"/> Educational Records/Files                        | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Criminal Justice Records/Files                   | _____   |

I want Lepage Associates and the following service providers or agencies to exchange this information:  
**(Please fill in names and provide telephone numbers if you have them.)**

- Therapist, Psychiatrist or Physician \_\_\_\_\_
- Community Mental Health Center \_\_\_\_\_
- Hospital \_\_\_\_\_
- Educational Institution \_\_\_\_\_
- Criminal Justice Agency \_\_\_\_\_
- Other \_\_\_\_\_

**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 Lepage Associates. This will stop the listed parties from sharing information after they know my consent has been withdrawn. I have the right to know what information has been shared, and why, when, and with who it was share if I ask.*

***I want the parties listed above to accept a copy of this form as consent to share information.***

\_\_\_\_\_  
(Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date Signed)