



CONSENT TO RELEASE & EXCHANGE INFORMATION FOR CUSTODY EVALUATION

I authorize the release and exchange of the protected information of:
(A new form must be completed for each child or parent; one form per person.)

(Please Print Full Name Legibly)

(Client's Date of Birth) (Client's Social Security Number)

I want the following confidential information about the client to be exchanged. **I acknowledge the data to be released may include information protected by law, and I authorize inclusion of this data.**

- Psychological/Psychiatric Records (Mental Health)
- Drug & Alcohol Assessment & Treatment Records
- Educational Records
- Legal Records (Civil & Criminal)
- Parenting References
- Medical Records (to include HIV/AIDS & other communicable diseases)
- Genetic Testing
- Other _____

Purpose: *I understand that the purpose of the use or disclosure and exchange are for custody evaluation, and that once disclosed there is no confidentiality, and the information will be re-disclosed to others as the evaluator asks follow-up questions, and could even appear verbatim in a report. I have been informed and understand that information disclosed pursuant to this Consent will be used only for the process of the evaluation for which it was obtained, but will be subject to redisclosure by a recipient of such information. It may be disclosed to the court, my attorney, or the opposing side's attorney, during the course of legal action related to the evaluation. Thus once disclosed, the privacy of the information is no longer protected under federal medical privacy law.*

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.*

Refusal: *I understand that I may refuse to sign this Consent. Refusal may delay evaluation. Consult your attorney.*

I (We) have read and understand the information on this Consent form.

My (Our) relationship to the client is: Self Parent(s) Guardian(s)

(Signature) (Printed Name) _____
(Date Signed)

(Signature) (Printed Name) _____
(Date Signed)

Please see reverse and fill in the names of individuals and/or agencies whom you give consent for.

5842 Fayetteville Road, Suite 106
Durham, NC 27713

I want Lepage Associates and the following service providers, agencies or collateral contacts to exchange this information: (Please check box, and fill in names and provide telephone numbers.)

Lawyer(s) _____

Therapist(s)/Psychiatrist(s) _____

Community Mental Health Center(s) _____

Physician(s) _____

Hospital(s) _____

Educational Institution(s) _____

Child Care Provider(s) _____

Extracurricular Activity Coordinator(s) _____

Relative(s) _____

Neighbor(s) _____

Criminal Justice Agency _____

Other _____
