Consent for Release of Information

I, _____
(Client Name) (Date of Birth) (SS#)

request and authorize Alcorn & Allison Clinical Associates to
❒Exchange with ❒Receive from ❒Provide to

_____
(Name and Address of Agency or Person to Provide or Receive Information)

information (in written and/or oral form) regarding:

- ❑ Initial Evaluation and Recommendations
- ❑ Treatment Summary
- ❑ Psychological Evaluation
- ❑ Progress Notes
- ❑ Duration of Treatment or Program
- ❑ Summary of Treatment Participation/Progress
- ❑ Coordination of Care
- ❑ Diagnosis and Assessment
- ❑ Physician Notification
- ❑ Social Skills and Behavior at School
- ❑ Appointment Times/Attendance
- ❑ Financial/Insurance Information

This information is for the purpose of:

- ❑ Assisting with the client's evaluation and treatment
- ❑ Coordinating services between Alcorn & Allison and agency or person named above
- ❑ Transferring information regarding previous treatment
- ❑ Planning and implementing therapy for the client and/or client family
- ❑ Determining if Alcorn & Allison services are appropriate for the client's needs
- ❑ _____

I understand that this consent will automatically expire on _____, 20___.

- I authorize you to send/receive copies of these records or reports to/from Alcorn & Allison Clinical Associates at the address shown on this form.
- I understand that my clinical record may contain psychiatric, mental health, developmental disabilities, alcohol and/or drug abuse information and/or Acquired Immune Deficiency Syndrome (AIDS) and/or HIV test results and information.
- I authorize the release of the information itemized above solely for the purpose itemized on this consent form. Only such information and/or records believed necessary for the purpose expressed above shall be released and disclosed. I may inspect and copy the information to be disclosed.
- I understand that I have the right to revoke this consent at any time. The revocation must be in writing and received by the person releasing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.
- I understand that the information received cannot again be given to any other agency or person without my written consent.
- I understand that I do not have to sign this authorization and Alcorn & Allison Clinical Associates may not condition treatment on whether I sign this authorization.

_____
Client Signature (For clients age 12+) Date

_____
Parent/Guardian Signature (For clients younger than 18) Date

_____
Alcorn & Allison Clinical Associates Staff Signature/Witness Date