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 Jayme Yodice, LPA 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)

My relationship to the client is: ☐ Self ☐ Parent ☐ Guardian

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

☐ Psychological/Psychiatric Assessment Information ☐ Medical Assessment Information
☐ Psychological/Psychiatric Treatment Records ☐ Medical Treatment Records
☐ Synopsis of Psychological/Psychiatric Treatment ☐ Synopsis of Medical Treatment
☐ Psychological/Psychiatric Diagnosis ☐ Medical Diagnosis
☐ Educational Records /Files ☐ Other _____
☐ Criminal Justice Records/Files _____

I authorize Jayme Yodice, LPA to send clinical information via email to those below: YES ☐ NO ☐

I want Jayme Yodice and the following providers/agencies to exchange this information:

(**Please fill in names and provide telephone numbers** if you have them.)

☐ Therapist, Psychiatrist or Physician _____
☐ 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 Jayme Yodice, LPA. This will stop the listed parties from sharing information after they know my consent has been withdrawn.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 whom it was shared if I ask.*

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

_____/_____/_____

(Signature) (Date Signed)