

Consent to Exchange Confidential Information

Client Name: \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize and request that Leslie B. Whiting M.Ed. LPC, and:

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To exchange confidential information regarding the treatment of the above-named client from the dates of \_\_\_\_\_ to \_\_\_\_\_

Information to be exchanged: Reason for Exchange:

\_\_\_\_ Complete mental health records \_\_\_\_ Requested by client

\_\_\_\_ Attendance and dates only \_\_\_\_ Phone Consultation

\_\_\_\_ Diagnosis & Treatment Summary \_\_\_\_ Referral \_\_\_\_ Subpoena

I understand that my records are protected under Federal (42CFR Part2) and State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person that is to make this disclosure has acted on reliance on it. Authorization will remain in effect for thirty days after I sign and date this form, unless otherwise specified. Upon revocation of consent, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires thirty days or will automatically expire on \_\_\_\_\_.

\_\_\_\_\_  
Client Signature      Date

\_\_\_\_\_  
Parent/Guardian Signature      Date

\_\_\_\_\_  
Witness      Date

**Prohibition on Redisclosure:**

This information has been disclosed to you from records where confidentiality is protected by Federal law. Federal regulations (42CFR Part2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information to criminally investigate or prosecute any alcohol or drug abuse patient is contained within (42CFR Part2 applies only to substance abuse records)