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CONSENT FOR RELEASE OF INFORMATION

Client Name: _____

Street Address: _____

City, State, Zip: _____

Date of Birth: _____

Home Phone: _____ Work Phone: _____

I, _____, authorize Peggy Derivan, MS, LMHC

___ To Release information to: (and/or) ____ To Obtain information from:

_____Primary Care Physician:_____

_____Phone Number:_____

_____Fax Number:_____

Information to be released:

_X__ Assessment/Evaluation ___ Treatment Plan/recommendations
__X_ Medical Assessment ___ Discharge Summary
___ Educational Testing __X_ Diagnosis ___ Progress Notes

___ Other: _____

Purpose of disclosure:

__X_ Evaluation __X_Treatment Planning __X_ Continuity of Care

___ Other: _____

This authorization shall be in effect for 12 months following the date of signature. I understand that I may revoke this consent at any time by notifying Peggy Derivan in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above. I also understand that the client's records are protected by Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. Any redisclosure of this information to a party other than to the one designated above is forbidden without additional written authorization on my part. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian (if under age 13) Date