

Consent to Exchange Confidential Information

Client Name: _____

SSN _____ Date of Birth _____

I hereby authorize and request that Cami Covey-Doucet, 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 This authorization may be withdrawn at any time in writing except to the extent that the program or person that is to make this disclosure has acted on reliance on it.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)