



# Attentive Family Services

*“attentively listening to you!”*

## Consent to Release and Receive Information

I/ (or minor child's name), \_\_\_\_\_ D.O.B \_\_\_\_\_

authorize Attentive Family Services, P.L.L.C to release and receive medical, academic, or mental health information regarding:

- |  |  |
|--|--|
| <input type="checkbox"/> Psychiatric Assessments / Evaluations | <input type="checkbox"/> Treatment / Service Plans               |
| <input type="checkbox"/> Psychosocial History                  | <input type="checkbox"/> Medications / Prescriptions             |
| <input type="checkbox"/> Medical Diagnosis & Collaboration     | <input type="checkbox"/> School Records, inc. behavioral reports |

Other \_\_\_\_\_

To: (Specify Physician, School, Agencies or Facilities Personnel, Insurance Co., etc)

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

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

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

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

**Purpose:** Coordination of care to promote the best treatment avenues for the above client/patient

Method of Information to be Release / Shared:

- Verbal     Photo Copy     Computer / Email     Fax     Face to Face

The medical and mental health information may be released to, or from, providers who provide continued care and other government agencies as required by law. I understand the medical information may include mental health history, diagnosis, medications, past hospitalizations, drug and alcohol abuse, HIV, acquired immune deficiency syndrome (AIDS), or other contagious diseases.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my consent. I certify that this consent has been given freely and voluntarily. I understand that services are not contingent upon my consent for release of information. I may revoke this authorization at anytime in writing by myself, except that action has already been taken on this consent and will automatically expire on the date specified below.

This consent to Release and Receive Information Expires One-Year after signing Date on: \_\_\_\_\_

Signature of Client or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Attentive Family Services Representative: \_\_\_\_\_ Date: \_\_\_\_\_