



Release of Information

NAME: _____

ADDRESS: _____

I hereby authorize _____, at FISHBEIN & ASSOCIATES PERFORMANCE CONSULTING, to release to and/or receive from _____ the following information from my clinical _____, medical _____, and/or school (provider) _____ file for the purpose of treatment planning.

- | | | |
|---|---|--|
| <input type="checkbox"/> medical/physical history | <input type="checkbox"/> psychological evaluation | <input type="checkbox"/> social assessment |
| <input type="checkbox"/> psychiatric evaluation | <input type="checkbox"/> neuropsychological evaluation | <input type="checkbox"/> educational report |
| <input type="checkbox"/> lab report | <input type="checkbox"/> psychoeducational report | <input type="checkbox"/> vocational assessment |
| <input type="checkbox"/> discharge summary | <input type="checkbox"/> chemical dependency evaluation | <input type="checkbox"/> progress reports |
| <input type="checkbox"/> other (specify) | | |

The purpose of this disclosure is to facilitate continuity of care.

This consent form expires on ____/____/____. Your provider and the person or place listed above can only exchange the information you have checked off in the list above. We cannot release the information to anyone else, and we can only use the information to help with your assessment or treatment. You may withdraw your consent for us to communicate with the other person or place at any time, in writing. If you withdraw your consent, it applies to new information, not to information we have already exchanged. You have the right to see and copy any information exchanged. You further understand that your refusal to consent to the release of information specified above will prevent disclosure of such information to the facility or individual named on this consent form.

DATE: _____ * _____
(Client) 18 years or older

DATE: _____ * _____
(Parent/Guardian) Under 18 years

DATE: _____ * _____
(Witness)