



## Informed Consent for Release of Information

(Consent expires 12 months from date signed)

I, \_\_\_\_\_, a client of Patti's Place, voluntarily authorize the exchange of the following verbal or written information as specified below. I understand that this information can become a part of my \_\_\_\_\_ record at both organizations. The purpose of this information exchange is to assist those involved in my care and treatment. I understand that Patti's Place will not release information to other parties without my own or my legal representative's written permission, except as required by law. I understand that I may revoke this authorization at any time.

The Patti's Place representative, \_\_\_\_\_ may contact those listed below:

Contact Information		Initials
Individual		
Agency		
Telephone Number		
Address		
Purpose:	<input type="checkbox"/> Case collaboration <input type="checkbox"/> Referral	<input type="checkbox"/> Supplement my record <input type="checkbox"/> Other _____

Written Information to be exchanged between Patti's Place and:		Initials
(name) _____		
<input type="checkbox"/> Psychosocial Assessment	<input type="checkbox"/> Plan of Care	
<input type="checkbox"/> Treatment Summary	<input type="checkbox"/> Discharge Summary	
<input type="checkbox"/> Diagnosis <input type="checkbox"/> Prognosis	<input type="checkbox"/> Other	

Parent or Guardian Signature for Minor		Date
Signature of Client or Legally Authorized Representative		Date
Patti's Place Representative Signature		Date