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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize and request that
(Print Client, Parent, Guardian or Legal Representative's Name)

Dr. Jill D. Sanders
(Print Dr. Name)

☐ Release ☐ Receive ☐ Bi-directional release (sharing)

all pertinent mental health (psychiatric/psychological), medical, educational, or legal information to/from:
(circle all that apply)

_____
(Name of person to be contacted) (Address)

Phone_____ Fax: _____

With the following exceptions or restrictions: _____ or **NONE**

Regarding: ___ My child (child's name): _____
___ Myself

For the specific purpose(s) of consultation, record review, continuity of care, and/or other: (Circle all that apply)

_____

I may revoke this consent at any time by so informing the above noted individual or clinic in writing. I understand that used or disclosed information released pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by HIPAA Privacy rules.

This authorization will be valid for ninety (180) days after which it will expire. However, releases of information or actions taken which were made contingent upon this authorization and which occurred before any revocation notice was received cannot be withdrawn.

Signature_____ _____
(Client) (Date)

Signature_____ _____
(Parent, Guardian or Legal Representative) (Date)