MY HEALING PLACE

Consent for Exchange of Confidential Client Information

I _____ (date of birth) _____authorize My Healing

Place or its representative to exchange information with _____

Concerning me or my child _____ (date of birth) _____.

Information requested:

___ School Records

___ Medical Records

___ Psychological Assessment

___Other:_____

___ Vocational Assessment

___ Psychological Tests

___ Treatment Summary

I understand I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon, and if not revoked sooner in writing this consent will expire one year from the date signed. A copy of this release is valid consent.

To receiving party of this information:
This information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed written consent of the person to whom it pertains is prohibited. These records may be protected by Federal Regulation (42 CFR Part 2.)

_____

Client Signature Date

_____

For child, parent, guardian, or authorized representative Date