Release of Information Consent

* indicates a required field

* Client/s name/s:
* Date/s of Birth respectively:

* I authorize (Practioner's Name):
* Practioner's most direct Phone Line:
* Practioner;s email address:
* Practioner's Office Name, City, State:

* To send the following information:

_____ Medical History Evaluations

__X___ Mental Health Evaluations, Developmental &/or Social History

__X___ Treatment Summary to Date (or Closing Summary)

__X___ Scanned Genogram would be much appreciated if available

__X___ Other: Verbal Communication for Collaboration of Care

To:
Transition By Design, Inc. via email: mail@TransitionByDesign.com

TBD Inc. Phones:
For Voice Mail Messages: 785-235-2500
For Phone Call or Text: 913-302-9101

*The above information may be used for the following purposes:

__X___ Planning for appropriate program with Collaboration of Care
__X___ Continuing appropriate program with Collaboration of Care
__X___ Case Review for Collaboration of Care
__X____ Preparation for Client-Anonymous Professional Case Presentation
__X___ Updating Files (for Closing Summary at the time when work is done or paused)
_____ Other:

—Release of Information Consent Continued—

I/we understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I/we further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I/we understand that this authorization is voluntary, and that information about the client's case may be used in a client-anonymous case consultation with peer professionals for the purpose of both the client's and provider's benefit. I understand I have a right to request a copy of this authorization. I understand I have a right to refuse to sign this authorization.

* Signature/s (if a couple or more than one party, both sign below):

  _____ _____

* Printed Name/s:

  _____ _____

  I consent to sharing the information provided here.

* Date: