CONSENT FOR RELEASE OR EXCHANGE OF PERSONAL AND HEALTH INFORMATION

PATIENT INFORMATION:

LAST NAME	FIRST NAME/MIDDLE INITIAL	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER

THE PERSON OR AGENCY BELOW MAY RELEASE OR *EXCHANGE* MY INFORMATION:	INFORMATION RELEASED OR EXCHANGED MAY INCLUDE:
Hillcrest Therapy Center **Kate Richards, LCSW** **101 North Woodrow Street** **Little Rock, Arkansas 72205** **Phone: 501-612-7254; Fax: 501-265-0057**	**__ All Information Relevant to Consultation** **OR (specify)** __ Psychological / Educational Evaluation Results __ Psychological Treatment and Diagnostic Records __ Billing and Payment Records __ Medical, Health, or Developmental Information __ Psychological, Behavioral, Educational Information __Other____

INFORMATION MAY BE RELEASED TO OR EXCHANGED WITH THE FOLLOWING PERSONS OR AGENCY(IES):	
Agency Name: ______________________________	Agency Name: ______________________________
Contact: ______________________________	Contact: ______________________________
Address:______________________________	Address:______________________________
City, State, Zip: ______________________________	City, State, Zip: ______________________________
Telephone: ______________________________	Telephone: ______________________________
Fax: ______________________________	Fax: ______________________________

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form, although disallowing collaboration between involved parties may limit the quality of services I receive from any of the agencies.

LENGTH OF TIME: This consent will be valid from the date that I sign this form until ___________ (date). If no date is entered, the form will be valid until *the date that I terminate services* with Hillcrest Therapy Center.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written notice to HTC and any other above specified person or agency. The withdrawal of consent will be valid as soon as HTC and the specified person or agency receives my notice, but will not apply to information that has already been shared after I signed the consent form and before notice of withdrawal was received.

SHARING OF INFORMATION: I know that my information may be shared more than once by the persons and/or agency(ies) listed above. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws. Hillcrest Therapy Center is not responsible for further release of information by other agencies.

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent form if I ask for one.

Signature:	Date: