202-847-7076
www.faa-pc.org

CONSENT FOR MUTUAL DISCLOSURE

I authorize the use, disclosure, or exchange of my Personal Health Information as described below:
Patient Name: _____Date of Birth: _____
I hereby give my permission to Francis & Associates, P.C. to use, disclose, or exchange my Personal Health Information **with this person or organization**:
_____

I am authorizing the use, disclosure, or exchange of the following Personal Health Information:

- o Dates of Service
- o Initial Evaluation & Diagnostic Impressions
- o Treatment Plan
- o Treatment Progress
- o Clinical Notes
- o Verbal Exchanges
- o Other:_____
- o Psychological Tests
- o School Records
- o Medical/Labs
- o Discharger Summary
- o Entire Record
- o View Record Only

This Personal Health Information will be used, disclosed, or exchanged for the following purpose(s):

- o Diagnosis & Evaluation
- o Formulation of Treatment Plan
- o Other:_____
- o Psychological Assessment
- o Comply with court-ordered evaluation

• I understand that if all items above or Entire Record are checked, the requesting person may receive the complete contents of my records, and that Francis & Associates, P.C. , cannot under a full release take responsibility for the disclosure of this information. It is assumed that parties to whom information is released will be discrete in disclosing information.
• I understand this authorization is voluntary. I understand that if the person / entity authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.
• I understand this authorization will be valid and in effect for 365 days from the date of signature, unless otherwise specified. I understand and agree that this Authorization will be valid and in effect until: _____.
• I understand that I can revoke or cancel this authorization at any time by sending a letter to Francis & Associates, P.C. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
• I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Francis & Associates, P.C.
• I affirm that I have had full opportunity to read and consider the contents of this Authorization, that everything in this form which was not clear to me has been explained, and that the contents are consistent with my direction.
• I acknowledge that I have received a copy of this completed form.

_____ _____
Parent/Legal Guardian Signature Date of Signing

_____ _____
Witness Patient Signature (if 18 or older)