Consent for Release of Information

I, _____, authorize Personal Health Partners and its contracted affiliates (i.e. service providers) to exchange the following types of information for the following purposes:

Personal Health Partners may exchange with _____ the following information relating to the clinical services I receive to support continuity of care or to inform them of my status for any of the following:

Social History ___,
Medical Record ___,
Treatment Summary ___,
Psychological Evaluation ___,
Insurance Information ___,

and/or

Other _____ Explain: _____.

This authorization shall become effective _____and is subject to revocation in writing by me at any time, except to the extent that action has already been taken. This authorization shall terminate _____ from the effective date, if not earlier revoked. I understand that this information will be used only for the purpose noted above and will not be disclosed to any other person or agency without my written permission.

_____ _____
Signature of Client or Legal Guardian (circle which) Date

_____ _____
Printed name of Client Date

_____ _____
Counselor's Signature Date

LYTLE EAP PARTNERS
Navigating Work...Life...Health