The Therapeutic Center for Children and Families

□ Andrew Lustbader, MD
□ Preston Wiles, MD
□ Jill L. Barron, MD
□ Jill Vaughan, APRN
□ Deirdre Trevett, APRN
□ Adrienne Nash, APRN
□ Maryellen Pachler, APRN
□ Catherine Lewis, LCSW
□ Amy McQuaid, LCSW
□ Leslie Greenblatt,, LCSW
□ Katherine Sullivan, LCSW

CONSENT TO RELEASE AND/OR OBTAIN INFORMATION

Client's Name: _____ Date of Birth: _____

I hereby authorize The Diagnostic & Therapeutic Center to release *and/or* obtain the information documented below:

- ❑ Admission summary or intake
- ❑ Discharge summary
- ❑ Summary of treatment(s)
- ❑ Psychosocial assessment
- ❑ Psychological testing
- ❑ Psychiatric evaluation/medication
- ❑ School reports
- ❑ Medical reports
- ❑ HIV information
- ❑ Alcohol and/or drug information
- ❑ Other _____

The information noted above will be _____sent to or _____obtained from:

Name: _____

Address: _____

_____

Telephone: _____ Fax #: _____

I understand that the federal and state confidentiality statues protect my personal health information. This material shall not be transmitted to anyone without my written consent or other authorization as provided in the aforementioned statues. I also understand that I may revoke this consent at any time, except to the extent that action has been taken and that this consent expires automatically one year from the date of signature unless otherwise indicated. The information to be obtained or disclosed was fully explained to me and was give of my own free will. I understand the medical record or clinical information to be released may contain information pertaining to psychiatric, drug and/or alcohol diagnoses and treatment and may also contain confidential HIV/AIDS-related information.

Client's Signature: _____ Date of Signature: _____

Parent/Guardian: _____ Parent/Guardian: _____