Alice Litter MSW LICSW

RELEASE OF INFORMATION

____I authorize Alice Litter LICSW and the healthcare provider(s) designated below to exchange medical and mental health information for the purpose of collaborating on and coordinating my healthcare.

____I do **NO**T authorize Alice Litter LICSW to exchange medical and mental health information with any healthcare providers for the purpose of collaborating on and coordinating my healthcare.

My consent applies to the following providers:

Name _____ Name _____

Address _____ Address _____

Tel _____ Tel _____

This consent does not extend to the release of any information regarding HIV/AIDS testing, diagnosis, or treatment, or genetic testing.

If there are any other limitations about the release of information, they are written here:

_____

I understand that I may change my mind and revoke this consent at any time by sending a signed and dated written notification to Alice Litter LICSW. I further understand that a revocation of the authorization is not effective to the extent that my provider has already acted in reliance on it.

This authorization expires in 1 year unless otherwise specified here:_____

I understand that if I choose not to give this consent, or if I change my mind and revoke this consent, this will not affect my eligibility to receive treatment.

Dated:

_____
Signature of client/legal representative or guardian

_____
Printed name of client/legal representative or guardian