Lauren Manasse, LICSW
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RELEASE/EXCHANGE OF HEALTH CARE INFORMATION

Name: ____ DOB: __________________
Address: ____
Telephone /Home:________________________ Work/Cell: _______________________

I hereby authorize Lauren Manasse, LICSW to:
OBTAIN FROM ____
PROVIDE TO ____
Institution/Attention:____
Address: ____
Telephone: _____________________ Email __________________________________

The purpose of the exchange of information is care collaboration and coordination.
Specific information to be exchanged:
____ Verbal information
____ Mental health records
____ Medical information
____ Psychological testing
____ Other
This authorization will be valid for 1 year from the signature date, or until: _________

Please return written information to Lauren Manasse, LICSW at the above address or call (617) 894 0024 to speak directly.

I have read and understand the above statements and voluntarily consent to disclosure of the above information about, or medical records of my condition, to those persons or agencies above. I further release my primary care provider, hospital and its employees from any liability arising from the release of this information to such persons or agencies, provided the release of information is done substantially in accordance with applicable law. I understand that this consent is subject to revocation in writing at any time, unless action based on it has already begun.

____
Client or Parent/Guardian or Legal Representative Date

____
Clinician Date